CARING FOR KIDS

NATIONAL GOVERNORS' ASSOCIATION

State Policy Reports

Health Studies

Strategies For Improving State Child Health Programs

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Strategies For Improving State Child Health Programs

by Ian T. Hill and Janine M. Breyel

Health Program
Human Resources Policy Studies
Center for Policy Research

National Governors' Association

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Executive Summary and Reader's Guide

Since 1986 virtually all states have invested significant energy and resources in the design and implementation of ambitious infant mortality reduction initiatives. Working collaboratively, state Medicaid and Maternal and Child Health program officials have strived to improve both access and quality in publicly funded prenatal care delivery systems.

However, the legislation that facilitated states' progress with pregnant women—laws that expanded Medicaid coverage of poor and near-poor mothers and their children—do not appear to have stimulated a commensurate level of interest and activity on behalf of children. By 1990, few states had addressed the question of how health care programs for children could be made more effective.

This picture changed dramatically with the passage and subsequent implementation of the Omnibus Budget Reconciliation Acts of 1989 and 1990 (OBRA-89 and OBRA-90). The laws first required all states to set minimum Medicaid income eligibility thresholds at 133 percent of the federal poverty level for children below the age of six, and then expanded this mandate to phase in, one year at a time, coverage of all children up to age nineteen living in families with incomes below 100 percent of poverty.

Critical provisions also were contained in OBRA-89 that promise to improve the quality of care provided to children. For the Maternal and Child Health block grant, the law required states to spend at least 30 percent of their funds on preventive and primary care for children and an additional 30 percent of funds on the care of children with chronic and disabling conditions. Even more important, the law asked states to make sweeping changes to their Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) programs—changes that will liberalize policies relating to the provision of preventive health and developmental examinations, the participation of providers, and the coverage of primary, acute, and specialty services.

To determine the scope and nature of state efforts to improve child health, the National Governors' Association surveyed state Medicaid and Maternal and Child Health program officials during the spring and summer of 1990. This report presents detailed information on states' responses to OBRA-89 and OBRA-90 and offers insights on how states can achieve further progress in improving the accessibility and effectiveness of their health care programs for children. (Pages 1-5)

PART I: SETTING THE CONTEXT

Determining Who Needs Care and Why

Passage of OBRA-89 and OBRA-90 could not have come at a better time. A growing body of evidence reveals that the nation's progress in improving children's health has slowed. The percent of low-birthweight births has not decreased since 1980. Immunization rates among children recently have declined; in 1983 more than one-third of children between the ages of one and four were not appropriately immunized.

Recent increases in the incidence of both measles and mumps substantiate this disturbing trend.

Even more distressing is the fact that the number of children living in poverty is increasing rapidly. Between 1979 and 1987, there was a 29 percent increase in this rate and, by the year 2000, one in four children will be living in poverty. The health status of poor children has been shown to be significantly worse than that of their more affluent peers. For example, problems such as child mortality, growth retardation and anemia, lead poisoning, unintentional injury, and physical abuse are seen much more frequently among poor children.

The strong correlation between poverty and poor health status is intensified by many children's lack of financial access to care. Of the more than 33 million Americans currently uninsured, one-third are children. Even those children that possess insurance are frequently not covered for the care they need—only 45 percent of conventional indemnity plans offered by private insurers cover well-child care. (Pages 7-16)

PART II: IMPROVING CHILDREN'S ACCESS TO CARE

Ensuring low-income children's access to care involves much more than simply expanding their eligibility for Medicaid. Families must be made aware of the availability of coverage and persuaded of the importance of well-child care. Eligibility systems must be made simple and convenient so that children can be enrolled in a timely manner. Finally, adequate numbers of pediatric providers must participate in Medicaid and agree to treat Medicaid-eligible children.

Enrolling Children in Medicaid

The Medicaid eligibility process is universally acknowledged as so complex and arcane that it probably succeeds in keeping significant numbers of applicants out of the program. Growing recognition of this problem has stimulated Medicaid and welfare officials to simplify and streamline the process in recent years. However, these reforms have been directed primarily toward improving access for pregnant women, not children.

According to the NGA survey, states are experiencing significant difficulty in enrolling many of the children who have been made eligible for Medicaid by recent state and federal expansions. Many factors contribute to this low enrollment, including certain requirements that make children's eligibility determination more complex than that for pregnant women, ineffective mechanisms for ensuring the eligibility of infants born to Medicaid-eligible mothers, and the lack of workable continuous eligibility protection for children.

An increasing number of states are attempting to address this problem. In most cases, strategies originally designed to streamline eligibility for pregnant women are being adapted for children. Promising efforts include outposting eligibility workers at high-volume pediatric provider sites, expanding the use of simplified applications forms, allowing families to submit applications by mail, and devising systems to enroll infants before their mothers' sixty-day postpartum eligibility period expires. (Pages 19-26)

Marketing Children's Coverage and Preventive Care

Outreach and marketing campaigns specifically targeting children and their parents are not a common component of most state Medicaid and Maternal and Child Health (MCH) programs. A majority of states have instead focused their outreach efforts on recruitment of pregnant women into prenatal care. The handful of states that have implemented campaigns stressing the importance of preventive well-child care and publicizing the availability of new coverage for children have built upon the successful themes, materials, and strategies already developed under perinatal initiatives. (Pages 27-29)

Accessing Pediatric Providers

States presently do not confront severe pediatric access problems. Unlike the case with obstetrical care providers, state Medicaid and Maternal and Child Health programs generally enjoy strong support from pediatricians. Unfortunately, the plentiful pool of pediatric providers willing to care for Medicaid children may be shrinking.

The NGA survey reveals that in nearly half the states public officials report either an existing or growing problem regarding pediatricians' willingness to serve Medicaid clients. These same officials report that the reasons typically given by pediatricians choosing not to participate are traditional—inadequate and/or delayed payment, excessive paperwork and cumbersome claims submission, and problems with patients.

State efforts to recruit or retain pediatric providers in Medicaid programs are not widespread at this time. Yet a handful of Medicaid and Maternal and Child Health program officials report new initiatives to prevent shortages from reaching crisis proportions or to address documented access problems. These efforts, which include increasing fees, restructuring payment systems and incentives, and improving provider relations often are built upon recent similar initiatives to recruit obstetrical providers into Medicaid, and are benefiting from the experiences of such proven strategies. (Pages 31-35)

PART III: RESTRUCTURING SERVICE SYSTEMS FOR CHILDREN

Devising a system for meeting the health care needs of children is a complex task. Such a system must be broad enough to provide every child with preventive, well-child services, responsive enough to treat any acute illnesses suffered by a child, and targeted enough to provide special services to those children with chronic health and/or developmental problems. At the heart of this issue is the question of how effectively are states operating their EPSDT programs and how well are states linking EPSDT with other service delivery systems.

Administering EPSDT More Effectively

Since the program's inception, state approaches to administering the EPSDT program have evolved in numerous and diverse directions. The decision regarding where to place responsibility for administering EPSDT is an especially critical one for states

and will greatly influence how and whether the program interacts with families on an ongoing basis.

The NGA survey found that more than half the states organize their programs around the Medicaid eligibility systems located in local welfare departments. Under a typical scenario, the eligibility worker who is responsible for gathering applicant information and making the eligibility determination also is responsible for giving the family an orientation to EPSDT and asking if the family wishes to participate in the program.

A very high proportion of states using this approach report dissatisfaction with its effectiveness. Confusion, anxiety, and information overload—inescapable by-products of a complex eligibility determination process—are the most commonly cited forces impeding effective EPSDT orientation in these states.

Using a very different approach, slightly less than half the states contract with entities—typically MCH programs—to carry out EPSDT management. In these states, local welfare offices determine general Medicaid eligibility and then forward family information to the local health department. Health department staff then directly contact families to discuss program benefits, identify children's needs, locate participating providers, make appointments, and arrange transportation. EPSDT specialists also follow up with each family to ensure that appointments are kept and services are received.

States using this approach report a much higher level of satisfaction with its effectiveness. From the perspective of both clients and program managers, EPSDT possesses a stronger identity as a *health care* program when administration is conducted by an agency other than the welfare department. (Pages 39-44)

Enhancing EPSDT Screening Services

One of the driving forces behind the EPSDT provisions contained in OBRA-89 was the concern that too few children were receiving EPSDT screens and that many children were not receiving the special types of screening services they needed. To address these concerns, the law prohibited states from limiting the pool of EPSDT providers only to those who can furnish all the required EPSDT services, or prevent from participating those providers who can furnish only part of the EPSDT service package.

This provision presents state officials with a classic "quality versus access" dilemma. Do rigorous EPSDT provider participation criteria that enforce the ideal of one-stop shopping improve the comprehensiveness and continuity of children's care, or do they unfairly exclude large numbers of providers who can otherwise effectively provide children with at least a portion of the EPSDT package?

The NGA survey found that few states know precisely how to respond to the OBRA-89 provision. While some states are restructuring their program to allow for various "partial" screening components, many are awaiting further clarification from Congress and the federal Health Care Financing Administration. Fueling this relative lack of action is the belief that disaggregating the EPSDT screen to allow multiple providers to render certain components will contribute to fragmentation

and undermine one of the prime tenets of the program: comprehensive and continuous care.

To address a related concern, many more states are taking steps to reduce the number of providers that render well-child care to Medicaid-eligible children *outside* of the EPSDT system—so-called "shadow" EPSDT providers. By providing physicians with greater incentives to render care to children through EPSDT and by gaining a better understanding of the types of providers who render well-child services, states hope to significantly improve the proportion of children participating in EPSDT. (Pages 45-53)

Linking Treatment to Screens

Despite its name, which indicates that screening, diagnostic, and treatment services are to be provided, EPSDT has always succeeded far better as a screening program than as a treatment program. Recognizing this traditional shortcoming, Congress included in OBRA-89 a provision requiring states to provide all services that are necessary to treat conditions identified during an EPSDT screen, whether or not those services are covered by their state plan.

In many states with traditionally generous benefits, state officials report little concern over the potential impact of this provision. Others, however, express significant concern about costs and utilization. Most often, these officials believe that the needs of the mentally ill and developmentally disabled will generate the greatest new demand. Therapeutic services for children with special health care needs are the optional Medicaid services most frequently not covered prior to OBRA-89.

In the aftermath of the treatment services provision of OBRA-89, states can choose to follow one of two possible courses of action: they can simply comply with the new mandate by reacting, on a case-by-case basis, to the individual treatment needs of covered children or they can proactively design a comprehensive treatment services benefit for this group.

Fortunately, a growing number of states have begun to consider the steps necessary to build a comprehensive health care system for children. To develop such a system, states see the need to establish strong relationships among Medicaid, MCH, and Children with Special Health Care Needs agencies. The NGA survey revealed that five states have recently designed and/or implemented programs that promise to improve the scope, continuity, and comprehensiveness of pediatric care under Medicaid. Further, a strong majority of states have begun serious interagency planning efforts. (Pages 55-61)

Building an Integrated Continuum of Care

Given the complexity of a comprehensive health care system for children—one that can meet the preventive, primary, acute, and special needs of all children—it is imperative that states develop mechanisms to ensure that systems operate in an integrated, coordinated manner. The NGA survey found that an overwhelming majority of officials are concerned about the lack of coordination in existing programs. This recognition is important because it similarly underlies the emphasis states have placed on prenatal care coordination in recent years.

Although support for coordinated care is singularly strong, current statutory and regulatory authority permit diverse approaches to care coordination. Some approaches emphasize administrative strategies for managing health care delivery, while others focus on direct provision of care coordination services.

Officials in states that have contracted with MCH programs (and other entities) for EPSDT management believe that a fundamentally coordinated program exists for preventive and primary care services. In these cases, federal administrative matching dollars support the activities of care coordinators.

However, to coordinate the care of children with more complex, chronic or disabling conditions, a large number of states recognize the need to develop a formal care coordination service. The optional targeted case management authority is being used in eighteen states to create a Medicaid-financed care coordination benefit for various subsets of the Medicaid-eligible child population. In most of these states, children with special health care needs are targeted.

In the most promising examples, a small number of states are linking systems that coordinate the delivery of preventive and primary care services to systems that manage utilization of specialty care. (Pages 63-67)

PART IV: NEXT STEPS

Taking Advantage of Available Opportunities

Reasons abound for feeling both seriously concerned and cautiously optimistic about the state of states' health care systems for children. While state initiatives in this area are lagging considerably behind those involving prenatal care, a number of factors may facilitate rapid progress in the future. States can build upon their successes in prenatal care and incorporate many of the lessons learned from these initiatives into strategies for children. Collaborative relationships forged between Medicaid and MCH agencies in recent years can form the foundation for these efforts.

Other opportunities are available to states striving to improve children's health:

- *Streamlining Eligibility*—Many of the same strategies used to simplify eligibility processes for pregnant women should be refined to achieve the same results for children.
- *Developing Children's Outreach and Marketing Plans*—Avoiding the need to reinvent the wheel, states should build upon successful and recognized prenatal care campaigns to develop strategies to promote the importance of well-child care and advertise the availability of new coverage.
- *Increasing Pediatric Provider Participation*—States should broaden current efforts to recruit and retain obstetrical care providers in Medicaid to incorporate and address the concerns of pediatric providers.

- *Developing Comprehensive Child Health Services*—States should revisit their EPSDT programs with an eye toward structuring a program that can meet the preventive, primary, acute, and specialty care needs of children. This process involves numerous steps, including:
  - Delinking EPSDT administration from the Medicaid eligibility process;
  - Expanding the base of providers participating in EPSDT while also striving to provide each child with a medical home;
  - Designing a comprehensive package of treatment services for children; and
  - Establishing an overarching coordination system.

For more than four years, states have placed unprecedented emphasis on the goal of improving the health status of mothers and children. To date, the lion's share of this effort has focused on infant mortality initiatives and prenatal care improvements. States are now beginning to refocus their energies on the needs of children. Eligibility expansions under Medicaid have enabled the first critical step: financial access. Yet much more work needs to occur before this nation's children will enjoy widespread access to the high-quality care they deserve. (Pages 71-73)

Part I: Setting the Context

1. Shifting the Focus to Children

Virtually all states have invested significant energy and resources in the design and implementation of ambitious infant mortality reduction initiatives. Working collaboratively, state Medicaid and Maternal and Child Health program officials have strived to improve both access and quality in publicly funded prenatal care delivery systems. This unprecedented activity was galvanized by the nation's slow progress in reducing the incidence of both low-birthweight births and infant deaths.

Since 1986, state progress has been facilitated by the annual passage of sweeping federal legislation permitting states to expand Medicaid coverage of poor and near-poor pregnant women and their children. And while these laws spurred reforms of systems serving pregnant women, they do not appear to have stimulated a commensurate level of interest and activity on behalf of children. To date few states have addressed the question of how preventive and primary health care programs for children can be made more effective.

These developments simply underscore the primacy states have placed on the goal of reducing infant mortality and do not necessarily reflect a serious policy or programmatic shortcoming. As supported by the research literature, increasing access to high-quality prenatal care is the most direct means available to states for improving birth outcomes.

Opportunities Presented by OBRA-89 and OBRA-90

Public perinatal care reforms have paved the way for progress in improving children's health. Having put in place many of the tools required to begin improving maternal and infant health, state and federal policymakers are now broadening their efforts to focus on children. The need for such attention could not be more urgent. The number of children living in poverty is increasing, and in a growing number of cases these children do not possess any form of health insurance.

Despite severe budget constraints, for two consecutive years the Congress has enacted laws that will greatly improve children's financial access to care. Effective April 1990, the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) required all states to set minimum Medicaid income eligibility thresholds at 133 percent of the federal poverty level for both pregnant women and children below the age of six. This statutory change required only marginal adjustments to states' coverage of pregnant women, since all but seven states were already covering this group at or above 100 percent of poverty. However, the mandate demanded very significant expansions of states' coverage of young children. Prior to OBRA-89 states were permitted to cover under Medicaid children up to age eight living below 100 percent of poverty. As of January 1990, just five states had used this authority to raise

coverage to children below age seven. (The upper age limit of eight was not yet permissible under the optional authority's phase-in schedule.) Nine other states covered poverty-level children below age six, twenty-five states set upper limits between the ages of two and five, and twelve states covered only infants below age one (NGA 1990). OBRA-89 therefore required thirty-six states (and the District of Columbia) to substantially raise their poverty-related coverage of children.

The Omnibus Budget Reconciliation Act of 1990 continued this trend by expanding Medicaid eligibility for larger groups of children. Effective July, 1, 1990, it called for all states to annually phase in coverage for all children up to age nineteen in families with incomes below 100 percent of poverty. Building on existing language to incrementally add children born after September 30, 1983, the law required all states to cover children below age eight by October 1990. The upper age limit will be reached by October 2001.

Congressional reforms have not focused solely on expanding Medicaid eligibility for children. Important provisions also were contained in OBRA-89 that promise to improve the quality of care provided to Medicaid-eligible children. Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program has long been considered a program with enormous potential. Yet policymakers and advocates criticized it for not effectively meeting the needs of eligible children. Responding to this criticism, OBRA-89 required states to modify and/or liberalize policies relating to the provision of preventive health and developmental examinations, the participation of providers, and the coverage of primary, acute, and specialty services.

With barriers to financial access reduced, states must now set about the more challenging task of implementing programs that effectively improve the health status of poor and near-poor children. Fortunately, there is some evidence that states are beginning to take the necessary steps.

NGA Survey of State Children's Health Initiatives

Simply increasing Medicaid eligibility for children will not ensure better access or improved health status. To achieve these objectives, states will have to develop many of the same types of policy reforms that they accomplished under prenatal care initiatives.

- To achieve widespread enrollment, families must be well informed of new program benefits and persuaded of the importance of preventive well-child care. To spread the word, effective marketing and outreach campaigns will need to be developed.
- Complex Medicaid eligibility processes can substantially hinder access for those families with children who seek assistance. Streamlining eligibility for children is an urgent priority.
- Insufficient numbers of pediatric providers and/or insufficient capacity in public health clinics can undermine the effectiveness of service delivery systems for children. States must continue trying to increase provider participation in Medicaid.

- Delivery systems must be flexible and coordinated, and the content of care comprehensive, to meet the multiple and diverse health care needs of children.

To determine the scope and nature of state efforts to develop more accessible and effective health care programs for children, the National Governors' Association (NGA) surveyed Medicaid and Maternal and Child Health program officials in each state and the District of Columbia. During the spring and summer of 1990, extensive telephone interviews were conducted to collect detailed information regarding state policy and program strategies. Survey questions focused on a broad range of issues, including efforts to simplify eligibility processes for children, develop outreach campaigns for children and/or families with children, increase pediatric provider participation in Medicaid, and improve the scope, content, and coordination of preventive and primary care services. State reports, legislation, and program manuals were reviewed and analyzed to complement survey response data.

A major focus of the analysis is how states are revising their existing EPSDT program in response to OBRA-89. Special attention is accorded to how Medicaid and Maternal and Child Health program officials are collaborating to produce more effective and comprehensive program reforms. The analysis highlights initiatives for preschool and school-age children but does not fully explore strategies specifically targeted on adolescents.

The eighth report to be developed under the National Governors' Association's ongoing project, *Facilitating Improvement of State Programs for Pregnant Women and Children*, this publication describes new and ongoing efforts by state Medicaid and Maternal and Child Health program officials to address the preventive and primary care needs of children. It is anticipated that the information will assist states in designing and implementing innovative continuums of care for this critical population.

2. Determining Who Needs Care and Why

There are many economic and ethical reasons why people support the goal of ensuring that all children are born healthy and stay healthy. A recent survey found that 71 percent of Americans feel that more money should be spent on health care for children because it is an investment in the future (National Association for Children's Hospitals and Related Institutions 1990). On an economic level, the United States needs healthy and productive citizens to remain competitive in the world market. Yet Americans also appear to feel a responsibility toward disadvantaged children that transcends economic concerns. A Gallup survey found that 75 percent of Americans are willing to spend more tax revenues on health screens for low-income children (NACHRI 1990). Another survey found that 86 percent are willing to pay higher taxes to feed and provide medical care for very poor children (NACHRI 1990).

Encouragingly, the health status of U.S. children has improved significantly in recent decades. Since 1950 the life expectancy of newborns has risen from 68.2 years to 74.9 years. According to the National Center for Health Statistics, infant mortality rates have dropped dramatically since 1950 from nearly 30 per 1,000 live births to 10 per 1,000 live births in 1988. Child mortality rates also have declined significantly. In 1960 there were 109 deaths per 100,000 children one to four years of age; by 1986 this figure had dropped to 52. Older age groups also have seen improvements. For example, the mortality rate for children ages five to fourteen declined from 46 per 100,000 in 1969 to 26 per 100,000 in 1986.

These improvements in children's health during the last thirty years are due to many factors, including advances in medical care, increases in the standard of living, and expanded public health efforts in sanitation, immunization, injury prevention, and education. Many childhood diseases, including measles, rubella, pertussis, and polio, have been virtually eliminated as a result of immunizations. Other indicators document improvements in children's health. For example, the number of cavities experienced by twelve-year-olds was reduced by one-half between 1971 and 1987 (U.S. Department of Health and Human Services 1989).

Although promising, these gains often pale when compared with those of other industrialized nations. For example, infant mortality rates in the United States have not dropped as significantly as in other developed countries, ranking the nation behind twenty others, according to the National Commission to Prevent Infant Mortality. Further, U.S. child mortality rates are 10 to 50 percent higher than those of other countries (Children's Defense Fund 1987).

Within U.S. borders, there is a growing body of evidence that the nation's progress in improving children's health has slowed. The percent of low-birthweight births has not decreased since 1980 (U.S. Department of Health and Human Services 1989). Immunization rates among children recently have declined; in 1983 more than one-third of children between the ages of one and four were not appropriately immunized (Children's Defense Fund, *Children 1990*). Only 37 percent of all infants were fully immunized against diphtheria, whooping cough, and tetanus (DPT) in 1983 (Office of Technology Assessment 1988). Recent increases in the incidence of both measles and mumps also suggest that immunization rates are declining (U.S. Department of Health and Human Services 1989).

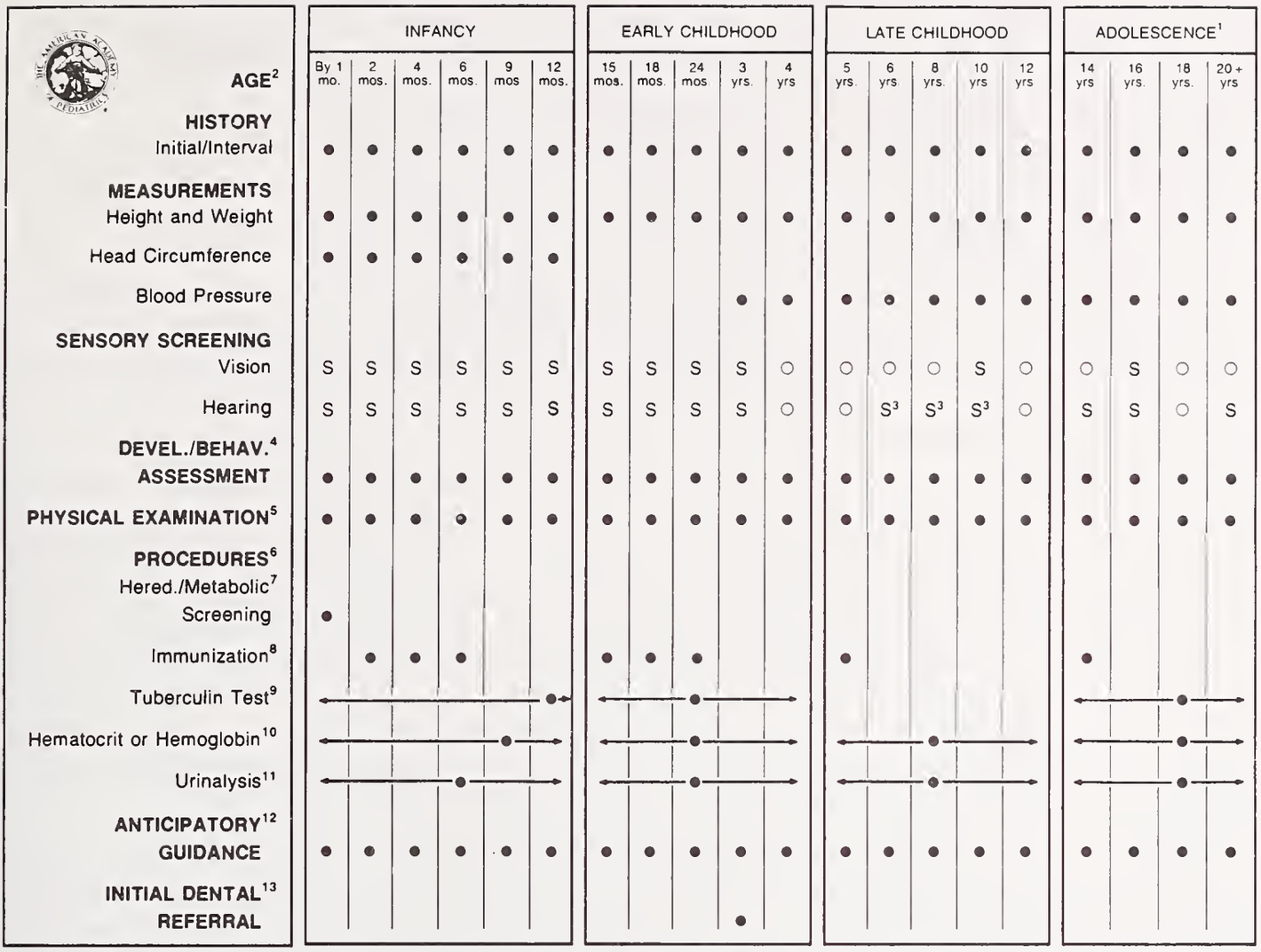
Health Services Needs of Children

What All Children Need. Primary care and preventive services traditionally are delivered in a variety of settings, including private physician offices, public clinics, and to a lesser extent, schools. The importance and cost-effectiveness of primary and preventive health care are well documented in the literature. Preventive care, early treatment of acute illnesses, and amelioration of chronic illnesses early in life may prevent more costly health problems later (Starfield 1982; Harvey 1990; Office of Technology Assessment 1988). Newborn screening for phenylketonuria, congenital hypothyroidism, and maple syrup urine disease is crucial for early identification of these treatable illnesses. If left untreated in the first few days or weeks of life, such conditions may result in severe mental retardation, physical disabilities, and even death (Office of Technology Assessment 1988).

Unfortunately, the effectiveness of well-child care in improving outcomes, as part of a broader primary care and preventive health care strategy, is not easily evaluated and has not yet been documented. However, expert opinion supports the efficacy of such care. Well-child care is an important preventive strategy, the goal of which is to "improve the physical, cognitive, and psychological health of children both in childhood and adulthood" (Office of Technology Assessment 1988). Well-child care typically consists of two components:

- *Physical Examinations and Health Supervision*. The American Academy of Pediatrics (AAP) recommends a certain number of preventive pediatric visits at specified intervals of a child's life, including six visits in the first year of life, three in the second year, one each year until age six, and one every two years until age twenty-one. Recommended examinations include screening for illness and developmental, hearing, vision, and dental problems, as well as health education and guidance to parents (see Figure 1).
- *Immunizations*. Proven to be cost-effective, vaccinations are given in this country for eight diseases—diphtheria, tetanus, pertussis (whooping cough), polio, measles, mumps, rubella (German measles), and Haemophilus influenzae b (Hib) (Office of Technology Assessment 1988). Studies have shown that for every dollar spent on immunizations, $10 is saved in avoided medical costs (University of North Carolina 1984). Furthermore, a fourteen-to-one benefit-cost ratio exists for the measles, mumps, and rubella vaccination (White et al. 1985).

Figure 1
Recommendations for Preventive Pediatric Health Care



1. Adolescent related issues (e.g., psychosocial, emotional, substance usage, and reproductive health) may necessitate more frequent health supervision.
2. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
3. At these points, history may suffice: if problem suggested, a standard testing method should be employed.
4. By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
5. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
6. These may be modified, depending upon entry point into schedule and individual need.
7. Metabolic screening (e.g., thyroid, PKU, galactosemia) should be done according to state law.
8. Schedule(s) per Report of Committee on Infectious Disease, *1986 Red Book*.
9. For low risk groups, the Committee on Infectious Diseases recommends the following options: ① no routine testing or ② testing at three times—infancy, preschool, and adolescence. For high risk groups, annual TB skin testing is recommended.
10. Present medical evidence suggests the need for reevaluation of the frequency and timing of hemoglobin or hematocrit tests. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
11. Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.
12. Appropriate discussion and counselling should be an integral part of each visit for care.
13. Subsequent examinations as prescribed by dentist.

N.B.: **Special chemical, immunologic, and endocrine testing** are usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, lead) are discretionary with the physician.

Key: ● = to be performed: S = subjective, by history: ○ = objective, by a standard testing method.

September 1987

SOURCE: American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, September 1987.

Efforts to improve the health status of children include many other strategies. Most notably are the education and prevention efforts that have long been a part of public health tradition. These fall into a broad range of categories, including preventing unintentional childhood injuries; preventing child abuse and neglect; and screening for blood lead poisoning. Such public health efforts have significantly lowered the morbidity and mortality rates of children in recent decades.

What Children with Chronic and Disabling Conditions Need. Many children have special, more complex health care needs. This population poses differing problems both in terms of what types of services they need as well as where their care is delivered. The definition of "special health care needs" encompasses a large array of handicapping conditions (including physical, developmental, and mental), and refers to a chronic illness or disabling condition that requires specialized health and related services. Examples of chronic conditions are asthma, cerebral palsy, cystic fibrosis, diabetes, hearing impairment, hemophilia, mental retardation, sickle cell disease, and visual impairment.

It is estimated that between 2 percent and 10 percent of all children have one or more special health care needs (Walker 1990). However, the number of chronically ill children appears to be growing, a trend that is especially alarming because of their intense medical care needs. As a percentage of the total population, the proportion of chronically ill children below age seventeen rose from 2 percent to 5 percent between 1960 and 1984 (Newacheck 1987). Ironically, advances in medical technology have been the major factor fueling this increase. They have contributed to better survival rates among premature, partially developed, and low-birthweight babies, and have enabled longer lives for children who survive prematurity, low birthweight, and severe chronic illness (Hall 1990).

Children with chronic conditions need a host of health care services, including therapies, social work, prescriptions, and psychological services. Because these services typically are provided in different settings by multiple providers, care coordination (or case management) often is necessary to ensure that their unique needs are met.

Children in Poverty

There is evidence supporting a strong correlation between children's poverty level and their health status. The insurance status of children and families also is closely related to poverty level and health status. These truths are especially distressing, given the increasing number of children living in poverty. In 1979, 25.3 million Americans were poor; of these, 10.1 million were children below age eighteen. By 1987, the number of poor persons had risen to 30.5 million, with 13 million below age eighteen. This represents an increase of 29 percent (U.S. Bureau of the Census 1990). It has been estimated that one in four children will be living in poverty by the year 2000 (Children's Defense Fund, *Children 1990*).

Today, one in five children lives in poverty. Children below age six are even more likely to be poor—one out of every four children in this age group currently lives in poverty (National Center for Children in Poverty 1990). Furthermore, poverty is disproportionately evident among minority groups. In 1987, among children

below age six, 48 percent of blacks, 42 percent of Hispanics, and 29 percent of other minorities were poor. Exacerbating the problem is the fact that families with children constitute the fastest growing segment of the homeless population in America. According to the U.S. Conference of Mayors, one in four homeless people living in cities is a child (Children's Defense Fund, *Children 1990*).

The growth in the number of children living in poverty is particularly disconcerting because such children have a poorer health status than that of their more affluent peers. According to the National Center for Children in Poverty:

- Child mortality is two to five times greater among poor children;
- Growth retardation and anemia are higher among poor children;
- Lead poisoning is three to four times more likely to occur among poor children;
- Unintentional injury is more frequent among poor children; and
- Child physical abuse is reported four times as often in families with incomes below $15,000.

Other indications of a lower health status among poor children can be seen in their rates of dental caries. The average number of decayed teeth, as well as the prevalence of Baby Bottle Tooth Decay, is higher in children from low-income families (U.S. Department of Health and Human Services 1989).

New and especially disturbing health problems also seem to be disproportionately found among low-income children. The number of infants who are born exposed to substances is growing at alarming rates, and while babies from all socioeconomic backgrounds are at risk, this risk seems to be higher for infants born to poor women (National Center for Children in Poverty 1990). Acquired Immune Deficiency Syndrome (AIDS) is yet another disease that is having a growing impact on children. Transmitted primarily through the mother, AIDS is the ninth leading cause of deaths in children between one and four years of age (Klerman and Parker 1991). Like substance exposure, pediatric AIDS is not confined to the poor, though 80 percent of all reported AIDS cases of U.S. children below age five are found among minorities, who are disproportionately low-income (House Select Committee on Children, Youth and Families 1989).

Moreover, chronic illness in children appears to be more prevalent among poor children (Congressional Research Service 1988). Since chemical addiction and Human Immunodeficiency Virus (HIV)-infection seem to be occurring more frequently in low-income populations, this is contributing to the rising number of poor children who suffer from chronic conditions.

Private Financing for Children's Health Care

The strong correlation between poverty and poor health status is intensified by many children's lack of financial access to health care. The children who need health care the most are those with the least access to such care. Of the more than 33 million Americans currently uninsured, one-third are children (Lewin/ICF 1990). This repre-

sents an increase of nearly 40 percent since 1977, when 8.1 million children below age eighteen were uninsured. A decline in private health insurance coverage since 1977 has contributed to this growth in the number of uninsured children. More than 73 percent of children had private coverage in 1977; by 1987 that figure had decreased to about 68 percent (Cunningham and Monheit 1990).

A recent study of children covered by a private health insurance plan or Medicaid found that coverage is strongly associated with family income. Ninety-two percent of children in families with an annual income of $40,000 or more were insured, while only 72 percent of children in families with an annual income of less than $10,000 had coverage. Almost 40 percent of poor children in intact families have no health insurance (Bloom 1990). Poor children with little or no health insurance coverage have limited access to health care. Among poor children in one recent study, the uninsured made 38 percent fewer medical care visits than those with insurance, and uninsured poor children less than two years of age were more than two times as likely to go without a medical visit (Parker, Greer, and Zuckerman 1988).

Poverty status also has an impact on where children receive care. For example, 92 percent of children who have health coverage have a regular source of routine care (i.e., a specific doctor, clinic, health center, or hospital) compared with 79 percent of children with no insurance (Bloom 1990). More than 14 percent of children living in poverty receive health care through an emergency room. Slightly more than 20 percent receive care in an outpatient department of a hospital (Office of Technology Assessment 1988).

Problems with the Cost of Coverage. Exacerbating an already bad situation is the rising cost of health care coverage. Escalating prices are driving many working poor and near-poor families out of the private insurance market. Premium costs for family coverage generally are much higher than those for individuals—$268 per month on average for a conventional family plan compared with $119 per month for typical individual coverage. Moreover, more employers now require their employees to pay a larger proportion of premiums. According to the U.S. Department of Labor, the number of employers requiring their employees to pay all or part of family health insurance premiums rose from 49 percent in 1980 to 68 percent in 1988. These factors contributed to the 25 percent decline in the proportion of low-income children with employer-based insurance that occurred between 1980 and 1986 (Rosenbaum 1989).

Cost-sharing provisions such as copayments, deductibles, and coinsurance are forcing low-income families to spend scarce resources for health care out of pocket. Many low-income families may be reluctant to incur these costs unless their children are really sick. Financial constraints often cause these families to avoid seeking preventive care for their children, especially since its importance is not always understood. One study found that 60 percent of children between the ages of zero and six received preventive care when covered by plans with no cost sharing requirements; this proportion dropped to 49 percent when cost sharing was imposed. Utilization of preventive services by children in plans with cost sharing was about 85 percent of the utilization by children in free plans (Lurie et al. 1987).

Problems with the Content of Coverage. Even families who manage to pay rising premiums, deductibles, and copayments are not assured they will receive coverage for needed health services. Widely used medical underwriting practices

may prevent children from receiving the services they need. Exclusions due to pre-existing conditions can be especially costly to families.

In addition, the coverage provided by many private insurance plans often is inadequate. Although about 74 percent of children are covered by private health insurance, according to the Current Population Survey of 1989, many of these policies do not cover preventive care for children. Unlike maternity services, which Congress mandated all private group insurance plans to cover in 1978, well-child care has not been accorded the same priority at either the federal or state level. Today only six states (Connecticut, Florida, Hawaii, Massachusetts, Minnesota, and Rhode Island) require insurers to provide well-child care coverage, and only Florida and Rhode Island require such coverage to extend to children above age six, according to the American Academy of Pediatrics. A 1988 Health Insurance Association of America (HIAA) survey revealed that only 45 percent of conventional indemnity plans offered coverage of well-child care, and 62 percent of preferred provider organization plans offered this coverage. This low rate of coverage occurred despite the fact that the average per capita cost of caring for children below the age of seventeen is only $500 (Parsons et al. 1986). Alternatively, health maintenance organizations (HMO), which tend to emphasize preventive care as a cost-effective measure, offered well-child care in nearly all of their plans. Coverage of general dental care is included in only 42 percent of conventional indemnity plans, according to HIAA's survey.

Public Health Programs for Children

Several coverage options are available for the 16.5 million children without private health insurance. Medicaid, the jointly funded federal and state program, is the major source of health care financing for the poor. However, the Current Population Survey indicated that of the 12.5 million children living below poverty in 1989, only slightly more than 8 million were enrolled in Medicaid.

Among the non-Medicaid sources of publicly funded support are Community and Migrant Health Centers. These centers offer no-cost or low-cost primary health care services in medically underserved areas.

Another source of assistance is the Maternal and Child Health block grant. This federal program awards states discretionary funds to provide health care to low-income, underserved pregnant women, infants, and children. States and localities also contribute their own funds to this program. In OBRA-89 Congress mandated that states spend at least 30 percent of their block grant funds on preventive and primary care for children. OBRA-89 also required states to spend, at a minimum, an additional 30 percent of these funds on the care of children with chronic and handicapping health care conditions. It is encouraged that all systems of care for children funded by the block grant be family-centered, community-based, and coordinated.

Under the Education for All Handicapped Children's Act (P.L. 94-142 as amended by P.L. 99-457), children meeting certain definitions of handicapped must receive nondiscriminatory education and health services. Part H of P.L. 99-457 requires states to provide services to infants and toddlers who meet the state's definition of handicapped or who are at risk of developing handicapping conditions. Federal funds are provided to states for planning services to these young children and their families. States are now in their third year of planning how to deliver these

services. By the fifth year they are required to have in place a system to ensure that these infants and toddlers are prepared for school.

While each of these programs plays a critical role in the nation's health care system for children, it is the Medicaid program that holds the greatest potential for financing the full range of care they need. Besides expanding Medicaid eligibility, OBRA-89 contained important provisions requiring states to significantly expand services through the Early and Periodic Screening, Diagnostic, and Treatment program. EPSDT is a program specifically and uniquely designed to enhance the provision of preventive care to Medicaid-eligible children.

The EPSDT Program. The EPSDT program was enacted under P.L. 90-248 when Congress mandated that states provide eligible children with screening, diagnostic, and treatment services through their Medicaid programs. Although the law was enacted in 1967, regulations for EPSDT were not promulgated until 1972. The program provides comprehensive child health to all Medicaid-eligible children up to age twenty-one.

EPSDT holds great promise for improving children's health care, though it is widely recognized that the program has not lived up to its potential. Participation rates have been low. In 1989 states reported that only 39 percent of Medicaid-eligible children participated in the program. An analysis of state data by the American Academy of Pediatrics (1990) revealed that in 1989 only 22 percent of Medicaid-eligible children received EPSDT services, and that on average, 1.3 percent of state Medicaid budgets was spent on EPSDT.

During the last twenty years, Congress has legislated numerous enhancements to EPSDT to ensure that the program's full potential is realized. OBRA-81 added an outreach component, requiring states to conduct informational activities in addition to screening, diagnosis, and treatment services. Outreach is not a typical component of Medicaid and most other government-sponsored assistance programs. In 1985 Congress called for EPSDT benefits to be consistent with established medical and dental standards. In addition, the law recommended that states enroll eligible children in continuing care arrangements to encourage more coordinated, comprehensive care.

OBRA-89 made the most sweeping reforms to the program. One provision requires states to provide any or all treatment services needed to treat a problem detected during screening, even if these services are not covered under the state's Medicaid plan.* The law also addressed the historically low rates of participation in EPSDT among Medicaid-eligible children by requiring the Secretary of Health and Human Services to set annual participation goals for each state. By 1995 all states are striving to achieve an 80 percent participation rate in their EPSDT programs.

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* It is interesting to note that the original proposal in 1967 would have required states to provide any treatment service needed to address a problem detected during a screen, whether or not that service was included in a state's Medicaid plan. The Nixon administration chose to limit EPSDT to only hearing, vision, and dental services, though states could waive comparability requirements to provide enriched services under EPSDT (Rosenbaum and Johnson 1986). With the passage of OBRA-89, Congress mandated states to do exactly what the original legislation proposed about twenty years earlier.

What EPSDT Provides. The EPSDT program is unique in its emphasis on preventive care. According to the Health Care Financing Administration's (HCFA) *State Medicaid Manual* (Transmittal No. 3), state agencies are required to:

- Seek out families with eligible children and inform them of the benefits of preventive care, the availability of health services, and the assistance for which they are eligible;
- Help children and their families use health resources effectively and efficiently;
- Assess children's health needs through initial and periodic examinations and evaluation; and
- Ensure that detected health problems are appropriately diagnosed and treated early, before they become more complex and costly.

As its name implies, EPSDT consists of three distinct service components: screening, diagnosis, and treatment.

Screening Services. Children participating in the EPSDT program must be screened periodically for health and developmental problems. At a minimum, screens must include:

- A comprehensive health and developmental history, including health education, nutrition assessment, immunizations, and development assessment;
- An unclothed physical exam;
- Laboratory tests;
- Vision testing;
- Hearing testing; and
- Dental screening.

To ensure that all states offer regular and timely screens, OBRA-89 codified regulations to require that screening, vision, hearing, and dental services are provided at intervals that meet "reasonable standards of medical and dental practice, as determined by the state after consultation with recognized medical and dental organizations involved in child health care."

Under OBRA-89 states also were mandated to develop distinct periodicity schedules for vision, hearing, and dental screens, and to provide screening services on an interperiodic basis as needed. In addition, the law requires states to screen all children ages one to five for lead poisoning.

Diagnostic Services. If a screening examination indicates the need for further evaluation, the EPSDT program covers diagnostic services. Once a suspected problem is detected by a screening examination, Medicaid agencies are required to refer the child for further diagnosis. This diagnosis is used to determine treatment needs.

Treatment Services. Medicaid agencies are required to provide treatment services to an EPSDT recipient if a need is indicated by a screen and if treatment is

deemed medically necessary. Prior to OBRA-89, states were required to provide only those treatment services that were already covered under their state plan. However, because EPSDT regulations permit the waiver of Medicaid comparability requirements, states could always provide enhanced services to children that were not provided to the rest of the Medicaid population. To date few states have taken advantage of this flexibility. Part 5 of the HCFA *State Medicaid Manual* suggests that states use their latitude to provide enhanced services for special populations within EPSDT such as at-risk infants or at-risk adolescents.

Is EPSDT Effective? Several studies have documented the effectiveness of the EPSDT program in improving children's health status and lowering their medical care costs. Most notably, a study of the Michigan EPSDT program in the early 1980s revealed that the medical costs for children participating in EPSDT were nearly 13 percent lower than those for nonparticipating Medicaid-eligible children. When the costs of administering the EPSDT program were taken into account, the difference in medical costs for participants and nonparticipants was 7 percent. The study also found a correlation between the number of screens a child receives and his or her rate of referral for further care. Children that received screens more frequently needed fewer referrals for medical problems. Specifically, referrals from screenings declined 4 to 9 percent as the number of lifetime screenings increased from one to four. Other EPSDT studies conducted in North Dakota, Pennsylvania, and Virginia have found similar cost savings and improved health status, documenting lower rates of hospital admissions and physician visits for those children in EPSDT compared with those not enrolled in the program (Keller 1983).

Although the health status of children has improved greatly during the last thirty years, comparisons with other industrialized nations reveal the slow pace of U.S. progress. Health indicators are even more dismal for the nation's poor children. And while programs like EPSDT have proven effective and are available to low-income children, the full potential of such programs has not been realized. Recent federal legislation expanding Medicaid coverage of poor children and renewing emphasis on primary and preventive care under the MCH block grant offers states opportunities to dramatically improve the delivery of health care to children.

Part II: Improving Children's Access to Care

Many barriers exist that can limit a child's access to health care services. The most fundamental barrier—lack of insurance—was significantly reduced for thousands of poor and near-poor children with the passage of OBRA-89 and OBRA-90. However, several additional steps must be taken before potential financial access is translated into real access to care.

- *Families must be made aware of the new availability of coverage so that they can come forward and apply for it on behalf of their children;*
- *Eligibility processes must be made simple, straightforward, and accessible so that children can be enrolled in a timely manner; and*
- *An adequate supply of pediatric providers must participate if Medicaid eligibility is to enable families to purchase the services they need.*

Portions of the NGA Survey of State Children's Health Initiatives were designed to reveal whether and how states are taking steps to help ensure access for newly eligible children. Results indicate a growing recognition by state officials that many of the same barriers they faced while trying to facilitate access for pregnant women also confront them as they address children's needs. Similarly, in a growing number of states strategies that helped mothers gain access to care are being modified and implemented to achieve the same result for children.

3. Enrolling Children in Medicaid

The Medicaid eligibility process is universally acknowledged as so complex and arcane that it probably succeeds in keeping significant numbers of applicants out of the program. Long and intricate forms, extensive verification requirements, and lengthy processing times produce a system that can actually present a barrier to access (Hill 1988).

Growing recognition of these shortcomings by state Medicaid and welfare officials has stimulated numerous administrative reforms to simplify the process during the last few years. However, these reforms have been directed primarily toward improving access for pregnant women. Unfortunately, children are not yet enjoying the benefits of such streamlining efforts.

Low Enrollment Rates

According to NGA's Survey of State Children's Health Initiatives, states are experiencing significant difficulty in enrolling many of the children who have been made eligible for the Medicaid program in recent years. In the aftermath of poverty-related Medicaid eligibility expansions, twenty-four states report that actual enrollment rates for children have fallen far short of anticipated rates. In only eight states do Medicaid and Maternal and Child Health officials believe that enrollment rates of newly eligible children are optimal. While most states did not have adequate data to precisely illustrate differences between numbers of potentially eligible and numbers actually enrolled, Table 1 provides information from seven selected states.

This trend contrasts sharply with the states' experience in enrolling pregnant women. Quantitative and anecdotal evidence generally suggests that states have successfully enrolled very high proportions of newly eligible women; in a number of states enrollment has actually exceeded projections (Hill 1988; Breyel 1990).

Why Is Enrollment Lagging?

There are numerous and diverse reasons why children who are eligible for Medicaid often do not gain access to the program. Some are deeply rooted problems that have hindered enrollment since the inception of Medicaid. Others are specific by-products of the legislation that has incrementally expanded Medicaid eligibility for pregnant women and children.

When asked to identify the factors that they feel contribute to low enrollment rates for children, state officials from the twenty-four states experiencing the problem offer these explanations:

Table 1
Children's Enrollment in Medicaid:
Actual versus Potential Participation

State	*Actual Number of Children Enrolled*	*Estimated Number of Potentially Eligible Children*	*Ratio of Actual to Potential Participants*
Colorado	386	2,500[1]	15.4%
Florida	34,000	81,000[2]	42.0%
Georgia	30,600	97,100[3]	31.5%
Indiana	53,300	105,800[4]	50.4%
Minnesota	17,326	34,000[5]	50.9%
North Carolina	25,504	36,607[6]	69.7%
Washington	4,134	7,775[7]	53.1%

NOTES:
1 Represents number of children below age one living in families with incomes below 75 percent of the federal poverty level.

2 Represents number of children below age six living in families with incomes below 100 percent of the federal poverty level.

3 Represents number of children below age six living in families with incomes below 133 percent of the federal poverty level.

4 Represents number of children below age six living with families with incomes below 133 percent of the federal poverty level.

5 Minnesota's Children's Health Plan supplements Medicaid eligibility by covering children below age eight living in families with incomes below 185 percent of the federal poverty level.

6 Represents number of children below age five living in families with incomes below 100 percent of the federal poverty level.

7 Represents number of children below age eight living in families with incomes below 100 percent of the federal poverty level.

SOURCE: National Governors' Association, Survey of State Children's Health Initiatives, 1990.

- *Families do not always recognize the importance of preventive health care and only seek health services in response to crisis situations.* Officials in sixteen states voiced this perennial concern, one that has traditionally plagued this nation's health care system. A lack of understanding of the importance of preventive services, coupled with a perceived lack of public support to finance that care, cause many families to avoid seeking health care until their children face a specific illness. Whereas pregnancy constitutes a specific condition that clearly demands attention, the need for regular well-child checkups and immunizations is not so readily apparent.

- *The Medicaid application process for children is complex and problematic.* State officials in fifteen states also highlight this situation as one contributing to slow enrollment. To date most of the eligibility simplifications that states have devised or have been permitted to implement by law have focused on pregnant women. For example, no provision for presumptive eligibility currently exists for children. Other constraints that have been lifted for pregnant women seeking Medicaid coverage—such as estab-

lishing paternity—are still required for determining children's Medicaid eligibility. Identification of the father for purposes of securing either financial or insurance support often can discourage the mother from applying for assistance. Moreover, the increasingly large number of states that have attempted to streamline access by outstationing eligibility workers at provider sites, shortening application forms, and expediting eligibility determinations have acted with pregnant women in mind. Such innovations have not yet been broadly applied to children.

- *Marketing and outreach campaigns publicizing expanded Medicaid coverage have typically focused on pregnant women, not children.* Officials in thirteen states believe that their outreach efforts, which have focused almost exclusively on persuading pregnant women to seek prenatal care, fail to effectively inform families of new, expanded coverage that may be available for their children. Without widespread publicity of the new coverage, the number of families coming forward to apply for Medicaid has been small. This has exacerbated the typical slow start-up curve that states usually experience with new Medicaid eligibility expansions.

- *Establishing eligibility for newborns has consistently proved problematic.* With the passage of the Deficit Reduction Act in 1984, Medicaid eligibility for newborns was to have been ensured. Any infant born to a Medicaid-eligible mother was to be automatically eligible for Medicaid as long as the mother remained eligible and as long as the child lived with its mother. This coverage was to be made available without requiring the family to submit a separate application on behalf of the newborn.

  However, the effectiveness of this provision has been mitigated by the eligibility rules established under subsequent laws. For example, since passage of OBRA-86, the vast majority of newly eligible pregnant women are qualifying for Medicaid by virtue of their pregnancy (and poverty-related income). Under the coverage provisions of that law, these women's eligibility only lasts through a brief sixty-day postpartum period. If during that time a separate application is not made for the child, that child's eligibility status also lapses on the sixty-first day. The sixty-day postpartum eligibility period for new mothers does not always allow sufficient time for an application to be made on behalf of the infant. Officials in thirteen states identify this as a significant problem that is causing hundreds of children to slip through the system.*

- *Effective, workable continuous eligibility protection for children is needed.* The same states that believe the brevity of the sixty-day postpartum

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* Ironically, a provision contained in OBRA-87 may have exacerbated this problem. To help ensure that an infant would not be denied services due to his or her uncertain eligibility status, this law permitted providers to bill against a mother's Medicaid identification number any services rendered to her infant immediately after birth. This temporary coverage actually has misled parents, providers, and some state policymakers into believing that an application need not be completed for the infant.

period is a problem, also express the need for establishing guaranteed eligibility periods for *all* children. These officials point out that pregnant women are afforded continuous coverage throughout their pregnancy and a sixty-day postpartum period by most states. Alternatively, children are subject to the normal Aid to Families with Dependent Children (AFDC) eligibility redetermination schedules used for all other populations. In some states this means that eligibility status must be reviewed each month and, depending on the outcome of that review, care can be interrupted time and time again.

Since this survey was conducted, the Omnibus Budget Reconciliation Act of 1990 was enacted. A casual reading of this law suggests that the continuous eligibility problem may have been resolved, at least for children below age one. Section 4603 of OBRA-90 states that continuous eligibility must be extended to all pregnant women throughout their pregnancy and a sixty-day postpartum period (previously a state option), and through an infant's first year of life, provided that the child remains in the mother's household and that the mother would be eligible for Medicaid if she was pregnant.

However, the final two clauses of this section leave doubt regarding the protection actually extended by the law. One reading suggests that states will have to continue to perform regular redeterminations of an infant's eligibility status in order to establish that the child continues to live with its mother and to repeatedly measure the mother's current income against the income eligibility threshold that would apply if she was pregnant. If this interpretation is correct, then OBRA-90 makes virtually no change to existing law. Infants still will be potentially subject to the on again, off again sporadic coverage that has always characterized Medicaid.

Another reading of the law gives cause for more optimism. Because continuous eligibility is now a guaranteed protection for every pregnant woman, regardless of fluctuations in income, a mother's income is not a determinant of the newborn's eligibility. The infant, who is now guaranteed eligibility for his or her first year of life, is living with a mother who is deemed pregnant and, since a pregnant woman is guaranteed continuous eligibility regardless of income fluctuations, so is the infant. States following this interpretation may forego any redeterminations of an infant's eligibility for one year and simply require all mothers to notify the state agency if their child moves out of the household.

Clearly, OBRA-90 does not decisively address the issue of continuous eligibility. At a minimum, Congress must clarify what it truly intended by Section 4603 so that states can implement the law appropriately. States in turn must develop administrative mechanisms that effectively routinize the establishment of both newborn and continuous eligibility. More important, OBRA-90 focuses only on guarantees for children below age one. The problem of interrupted eligibility for older children remains. Redetermination schedules that range from one to six months can still cause untold numbers of children to lose coverage and, therefore, access

to care. The NGA survey found that a number of states support the notion of a one-year eligibility period for *all* children under Medicaid.

Strategies for Streamlining Children's Eligibility

One objective of NGA's Survey of State Children's Health Initiatives was to determine the extent to which states are actively streamlining eligibility systems for children as they have for pregnant women. Further, state officials were queried about the types of strategies they feel are necessary or worth investigating.

Survey results indicate that very few states have begun to aggressively address the eligibility system barriers affecting children. However, many have begun to analyze the shortcomings of the process and seem poised to pursue reforms. In most cases, such action hinges primarily on determining how streamlining efforts for pregnant women can be refined to work equally well for children.

Outstationing Eligibility Workers at Pediatric Provider Sites. One of the most effective strategies states have used to facilitate pregnant women's access to Medicaid is outstationing eligibility workers at prenatal care provider sites. By July 1990 nineteen states had, to varying degrees, placed official social services staff at locations such as public health department clinics, hospitals, and Community and Migrant Health Centers (NGA 1990). These states uniformly report high levels of satisfaction with both the efficacy and efficiency of the approach, asserting that women can easily complete their Medicaid application at the same time they visit their prenatal care provider.

The NGA Survey of State Children's Health Initiatives asked states if they have ever used this approach in pediatric provider sites to enroll larger numbers of children into Medicaid. Only two states could point to outstationing strategies that are specifically designed to enroll children into Medicaid. Since 1987 Florida has been employing large numbers of outstationed workers in its system. Today 378 workers are stationed at 215 sites across the state. Of special note, these eligibility specialists have been placed at 94 county public health units (where 75 percent of all EPSDT screens are conducted) and at eight Children's Medical Services clinics (the state's program for Children With Special Health Care Needs). New York has begun pilot programs in two WIC clinics. Outstationed workers enroll both women and children, but they have been asked to focus specifically on enrolling children at nutritional risk.

Ten other states (Alabama, California, Connecticut, Maryland, Louisiana, Mississippi, North Carolina, Tennessee, Texas, and Utah) report that the primary focus of their outstationing initiatives is to enroll pregnant women. However, these states indicate that they are increasingly recognizing the potential for outstationed workers to also identify and enroll children.

Shortening Application Forms for Children. When OBRA-86 delinked eligibility for Medicaid from eligibility for AFDC for pregnant women and children, states were afforded the flexibility to simplify application forms. With the added option to ignore assets for these groups during the eligibility determination process, even more potential was created to eliminate the more complex aspects of these

forms. By July 1990 twenty-five states had taken advantage of these opportunities and designed special, shortened forms for Medicaid-only coverage of pregnant women (NGA 1990). Some of these forms have been reduced to a single page.

The NGA survey asked states whether they use shortened forms for children. The responses indicate that a small but growing number of states are pursuing this strategy.

In seventeen states, children currently have their eligibility reviewed based on a shortened application form (Alabama, Arkansas, Colorado, Delaware, Georgia, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Mexico, New York, South Carolina, Vermont, Washington, West Virginia, and Wisconsin). In all cases the same application form is used for both children and pregnant women. In states such as Arkansas, New Mexico, New York, and Washington the shortened form (about six pages) is used for all populations.

In six other states (Alaska, Hawaii, Michigan, Missouri, Ohio, and Utah), officials report plans to develop new shortened forms that will be used for both pregnant women and children or to adapt existing forms for pregnant women so that they can be used for children.

Allowing Families to Submit Applications by Mail. With the advent of shortened, simplified application forms, a growing number of states are recognizing the potential that mail-in applications hold for increasing access. By leaving blank forms in obstetrical providers offices and by permitting potential eligibles to submit applications and documentation to state social services offices through the mail, many states began facilitating enrollment of pregnant women during the late 1980s.

More recently, states such as Alaska, Georgia, Massachusetts, West Virginia, and Vermont have begun placing blank Medicaid application forms at health care provider sites where children are served. In addition to hospitals and health department clinics, West Virginia has placed these applications in the offices of all participating pediatricians in the state. Staff at sixty-three WIC clinics assist Vermont families in completing Medicaid applications for women and children, and then forward them to the state's public welfare department.

Expediting Eligibility Determinations for Children. Because the receipt of early prenatal care is so important to the development of a healthy fetus, a number of states believe it is wise policy to expedite the processing of Medicaid applications by pregnant women. Rather than placing their applications at the end of the queue, where up to forty-five days may elapse before approval or denial, officials in eleven states report instituting quicker turn-around time limits ranging from three to ten days (NGA 1990). Such strategies facilitate early access to prenatal care.

According to the NGA Survey of Children's Health Initiatives, state officials do not seem to believe that similar special handling for the applications of children is warranted. Because children who require care typically are not under the same urgent time constraints as pregnant women who need prenatal care, officials often report that expedited processing is not justified.

To date only two states—Georgia and Wisconsin—apply the expediting policy to both pregnant women and children. In Vermont the children of a pregnant

woman who is applying for aid have their applications processed within ten days by virtue of their mother's pregnancy. Washington also is considering plans to extend its expedited processing rules for pregnant women to children.

Facilitating Children's Enrollment Through Other Strategies. A number of states are using other strategies to enroll more children into Medicaid. Some of these involve the adaptation or application of policies originally developed for pregnant women, while others represent new efforts specifically devised for children.

- States with perinatal care coordination programs are increasingly asking care coordination providers to assist entire families, not just pregnant women, in obtaining Medicaid eligibility. Programs in eleven states (Alabama, Alaska, Delaware, Idaho, Maryland, Mississippi, New Mexico, North Carolina, Tennessee, Utah, and Virginia) have issued such guidance. Care coordinators can play an especially effective role by helping a new mother establish eligibility for her newborn during the sixty-day postpartum coverage period. Similarly, when serving a pregnant client, the care coordinator can help pursue eligibility for other children in the family.

- To ensure that greater numbers of newborns establish Medicaid eligibility, Kentucky devised a special process to initiate a Medicaid application at the time of delivery. Medicaid officials had received numerous complaints from pediatric providers who reported that an unusually high number of claims submitted for services delivered to infants were being rejected. An internal audit revealed that one of every two babies born to Medicaid mothers was not becoming eligible for the program. To address the problem, a new form was designed that can be completed by either obstetrical or pediatric providers in the hospital at the time of delivery. Upon submission to the Medicaid agency eligibility can be granted, thereby ensuring continuity of care.

- Delaware uses a different approach. All mothers are contacted upon the sixtieth day of their postpartum eligibility period to redetermine the eligibility status of their infant. Eligibility workers contact mothers by telephone to determine whether or not family and/or income status has changed since the birth of their infant. If no changes have occurred, eligibility is continued until the six-month anniversary date is reached, thereby placing the child in the normal six-month eligibility redetermination cycle used for all Medicaid recipients.

- In New York state officials are piloting a program that would verify such information by mail rather than by phone. Under the pilot, all new mothers would be mailed a recertification form shortly after their delivery. Mothers would be asked to complete the form before the sixtieth day postpartum so that a separate eligibility case can be established for the newborn. Washington uses a similar mail recertification process.

- The California Medicaid agency received approval from the HCFA regional office to automatically grant eligibility to babies born to Medicaid mothers, provided other children in the family are already eligible for

Medicaid. Rather than process a new application, the newborn is assumed eligible if the newborn's siblings are Medicaid-eligible. Therefore, the Medicaid agency automatically generates an identification card for such newborns and families are spared the burden of completing an additional application form.

- Some states utilize special training sessions for providers to foster increased enrollment of children. In West Virginia Head Start providers received orientation sessions on Medicaid eligibility and can now assist parents with filling out applications on behalf of their children.

Since 1986 states have made great strides in simplifying and streamlining their eligibility systems. To date the vast majority of these efforts have been aimed at facilitating access for pregnant women. As the NGA Survey of State Children's Health Initiatives indicates, problems still surround the enrollment of the thousands of children that have been made potentially eligible for Medicaid. Enrollment rates for children appear to be lagging significantly when compared with those for pregnant women.

The survey findings reveal the potential for improvement in the years ahead. Most of the strategies developed for pregnant women are readily adaptable for children. A growing number of states are employing strategies such as outposting eligibility workers at pediatric provider sites, expanding the use of simplified application forms, allowing families to submit applications by mail, and devising systems to enroll infants before their mothers' sixty-day postpartum eligibility period expires. If more states are able to pursue these and other innovations, Medicaid enrollment rates for children should improve.

4. Marketing Children's Coverage And Preventive Care

Outreach and marketing campaigns specifically targeting children and their parents are not common components of most state Medicaid and Maternal and Child Health programs. With the passage of OBRA-89 and OBRA-90, which require extensive Medicaid eligibility expansions and service enhancements for children, the need for outreach activities clearly exists.

Campaigns highlighting the new availability of Medicaid coverage for children and stressing the value of preventive well-child care services have not yet been developed or funded in many states. A majority of states have instead focused their outreach efforts on recruitment of pregnant women into prenatal care. These efforts have used various marketing strategies such as broad mass media campaigns, toll-free informational hotlines, and community-based case finding (NGA 1990). Capitalizing on the Health Care Financing Administration's increased willingness to provide federal administrative matching funds for outreach, many perinatal outreach initiatives have achieved impressive scope, professionalism, and appeal.

Only a handful of states have implemented comprehensive campaigns to recruit greater numbers of children into care. Not surprisingly, the most promising of these build upon the successful themes, materials, and strategies already developed under perinatal initiatives.

Minnesota has designed an outreach campaign specifically targeting families with young children. Since July 1988 the state has operated the Children's Health Plan, a program that builds upon Medicaid to provide state-funded health insurance for all children up to age eight living in families with incomes below 185 percent of the federal poverty level. To publicize the program, the state has developed a multipronged outreach campaign that uses direct mailings, brochures, posters, and telephone and radio public service announcements. The materials contain the dual messages that coverage is available for those who need it and, more broadly, that comprehensive preventive care is important.

State officials have gone to great lengths to ensure that multiple federal, state, and local programs refer their clients to the Children's Health Plan. WIC, public schools, and Head Start programs currently provide the largest number of referrals. The effort is credited with helping the state achieve impressive enrollment rates. During the program's first twenty-four months, 51 percent of projected eligibles were enrolled. This kind of progress helped persuade the state legislature to expand the initiative. Effective January 1991, the Children's Health Plan covers all children between the ages of one and eighteen living below 185 percent of poverty.

New York's Medicaid and MCH agencies have recently contracted for the development of a statewide multimedia campaign that will promote the importance of preventive care for pregnant women and young children. The campaign will begin in the spring of 1991 and will employ radio and TV public service announcements, various printed materials, and a toll-free hotline to spread its message to families in need of assistance.

UTAH has run its Baby Your Baby perinatal outreach campaign since 1988. The project has been widely praised for both its ambitious and multifaceted design and attractive and exciting materials. By communicating the message of the importance of prenatal care to the entire populace, rather than to Medicaid and/or low-income populations, the program has achieved a 90 percent name recognition rate among Utah residents. Capitalizing on this success, state officials recently have launched a second phase of Baby Your Baby that expands its message to persuade families to obtain early and continuous well-child care.

Following a strategy similar to that used in the first phase, a broad-based coalition of interested groups was formed including the Utah Department of Health, the local NBC affiliate-KUTV, and an association of independent nonprofit hospitals. Members jointly designed a diverse campaign that incorporates television and radio public service announcements, print advertisements, direct mailings, ongoing correspondence, and patient incentives to communicate the message. Facets of the effort include:

- A series of six "Newborn Newsletters." The newsletters are mailed to all women giving birth in the state throughout their infant's first eighteen months of life.
- A new series of television and radio public service announcements, and specially focused, thirty-minute television specials. These are broadcast statewide at different times each day, including some during prime time.
- An expanded 1-800 hotline for families to call for information. The hotline retains the name and number used for the initial phase of Baby Your Baby.
- A four-color, 120-page newborn handbook, "Baby Your Baby Health Keepsake." Patterned after Japan's prenatal care passport, the Keepsake is a portable record that can be used to track and enhance a woman's use of prenatal care and her baby's use of preventive pediatric care. More than 35,000 copies were distributed to obstetricians, pediatricians, family practitioners, hospitals, and public health clinics at the outset of the campaign. On an ongoing basis, all women who call the 1-800 hotline receive a free copy of the "Baby Your Baby Keepsake." The Keepsake, which offers helpful, easy-to-understand descriptions and benchmarks for prenatal and well-baby development, provides space for mothers to write down questions for their providers, and structures a complete series of visits for both mother and baby to facilitate comprehensive utilization.

Of special import, Utah has devised a creative way of using the outreach plan to feed information into a new, statewide high-risk infant tracking system. Linking birth certificates and newborn metabolic and other screening forms, the health department develops a detailed database that identifies all high-risk births—at last count about 18 percent of all births in the state. Health department staff then contact the families and providers of these infants to organize well-child care, familiarize them with the Baby Your Baby campaign, and send them a Keepsake. Within the Keepsake are two perforated, tear-out postcards containing questions that secure critical information regarding each baby's progress. At the two-week and eighteen-month well-baby visits, pediatricians have been instructed to fill out these postcards and forward them to the state's high-risk tracking system. Parents are given an incentive to ensure their providers comply with the request; upon receipt of the postcards state officials send the families various gifts, including T-shirts and discount coupons for items such as baby pictures. Through this innovative process—that actively involves both providers and family members—state officials hope to be better equipped to meet the needs of children with special problems.

California, Indiana, Missouri, Vermont, Washington, and Wisconsin also have plans to build upon prenatal care outreach efforts to incorporate themes relating to preventive well-baby care.

The NGA Survey of State Children's Health Initiatives confirms that few states are actively developing outreach campaigns aimed at improving the use of primary and preventive care by children. Instead, the majority of states describe efforts focusing on childbearing women and the importance of prenatal care. Given states' commitment to reducing infant mortality, this finding is not surprising. However, it also seems clear that they must broaden their priorities in the near future. Eligibility and service expansions contained in both OBRA-89 and OBRA-90 will increase the pressure upon states to enroll greater numbers of children in Medicaid.

5. Accessing Pediatric Providers

Significant headway in improving pregnant women's access to prenatal care has been consistently thwarted in recent years by a severe shortage of obstetrical care providers. Public program officials in nearly every state have expressed extreme frustration in mitigating the effects of the growing number of obstetricians who are refusing to treat pregnant Medicaid recipients (Lewis-Idema 1988; NGA 1990).

In contrast, Medicaid and Maternal and Child Health administrators historically have enjoyed excellent relations with pediatric providers. Pediatricians tend to be more public health-oriented than other physician specialists, and public officials often credit them with being more altruistic in their willingness to serve low-income populations. Unfortunately, the plentiful pool of pediatric providers willing to care for Medicaid children may be shrinking.

A recent study by the American Academy of Pediatrics found declining proportions of member-pediatricians willing to accept Medicaid patients. The 1989 survey found that between 1978 and 1989, pediatricians' willingness to treat all Medicaid beneficiaries requesting care declined from 85 percent to 77 percent. The proportion of pediatricians willing to treat only some of those beneficiaries requesting assistance increased during the same period from 25 percent to 39 percent (Yudkowsky, Cartland, and Flint 1990).

Information gathered through the NGA survey generally supports the results of the AAP research and suggests many states are finding insufficient numbers of pediatric providers willing to serve publicly insured children. In response to the question, "Is a lack of availability of pediatric providers posing a problem in your state?", twenty-one states replied no. Eleven other states perceive a problem to be developing. Eleven more states said that they are currently experiencing a problem. Medicaid and Maternal and Child Health officials in four states gave conflicting answers to the question. In no state did officials indicate the shortage is as serious as that for obstetrical providers, though the numbers seem to suggest a growing problem.

Reasons for Nonparticipation

When asked to report the reasons pediatricians typically give for not participating in Medicaid, state officials cite many of the traditional complaints that are often lodged against the program. As indicated in Table 2, inadequate payment levels is the leading reason. Other key problems include excessive paperwork/cumbersome claims submission, problems with patients, and delayed receipt of payments. Conspicuously low in this ranking is malpractice liability. Unlike obstetrical care

providers, pediatric providers face relatively little malpractice risk. In only three states did officials mention that some pediatricians worry about problems arising from a child's adverse reactions to an immunization. Such concerns have been dramatically reduced since the enactment in 1987 of the federally financed no-fault Vaccine Injury Compensation Program.

Table 2
State Reporting of Principal Reasons for Provider Nonparticipation

Reasons for Not Participating	*Number of States*
Low/Inadequate Fees	36
Excessive Paperwork/Administrative Burden	30
Problems with Clients	21
Delayed Payments	14
Malpractice Liability	3

SOURCE: National Governors' Association, Survey of State Children's Health Initiatives, 1990.

Steps to Recruit and Retain Pediatricians

When asked whether any specific actions are being taken to improve pediatric provider participation rates, more than half the states described one or more new initiatives. According to the NGA Survey of State Children's Health Initiatives, thirty-one states have raised fees for pediatric providers or are planning to do so. The reasons for enhancing reimbursement rates and methods are twofold. First, fee increases are seen as a necessary first step to either maintain or increase participation. Second, a provision of the Omnibus Budget Reconciliation Act of 1989 is pushing states to adjust fees. Section 6402 requires states to annually demonstrate that the fees they pay to obstetrical and pediatric providers are sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries, to at least the extent that such services are available to the general population. While there is still great uncertainty about how states will demonstrate compliance with this provision and how the federal government will measure "equal access," OBRA-89 seems to have stimulated many states to review and update their reimbursement rates. A table in the Appendix details the fees states paid in 1989 for EPSDT comprehensive screens. While most states have simply increased fee schedules by certain percentages, Michigan and New York have chosen to restructure their entire system of payment for well-child care.

State strategies to boost pediatric provider participation are not focusing solely on fee adjustments. Thirty-eight states have specific outreach efforts to directly solicit the participation of private pediatricians and other pediatric specialists. These states generally speak of very positive and cooperative ongoing relationships with AAP chapters, especially when compared with associations representing other physician specialties.

State initiatives include establishing special or regularly scheduled pediatric advisory groups, conducting targeted surveys of pediatricians to elicit their concerns

Beginning in October 1990, **NEW YORK** implemented its Preferred Physicians and Children Program (PPAC). Developed with the consultation of a twelve-member physician advisory panel, PPAC was designed by the Medicaid agency to achieve two primary goals: to increase children's access to primary care by encouraging broader physician participation, and to reinforce the quality of care rendered to low-income children.

To accomplish the first goal, a threefold increase in numerous well-child and primary care fees was instituted, bringing Medicaid rates up to levels comparable with those of private insurance. (For example, the fee for a well-child visit is now $44.00 for doctors in the greater New York City area, and $36.67 in other areas of the state.) To accomplish the second goal, the enhanced reimbursement is made available only to those physicians who make certain assurances to the state that they will provide continuous and comprehensive care.

Physicians who choose to participate in PPAC must meet several eligibility requirements. They must possess active hospital admitting privileges and board certification in primary or certain nonprimary care specialties. They must be available on a twenty-four hour basis and must participate in the Child/Teen Health Plan (New York's EPSDT program). Preferred physicians also are required to coordinate medical services for their child patients, arranging for all diagnostic consultations and ancillary services. To make the program even more attractive to physicians, billing processes have been simplified. PPAC uses a standard claim form that is accepted by Medicaid, Medicare, and Blue Cross/Blue Shield. Electronic claims submission is permitted. All enrolled physicians also receive training and technical assistance in the new claims methodology from the state's fiscal agent.

By including physician advisors representing members of the American Academy of Pediatrics and the American Academy of Family Practice in the design stage, New York has been able to enlist the active support of the private provider community in promoting PPAC. Recruitment and provider outreach efforts are the shared responsibility of state officials and the state medical association. Early responses have been very positive; during the first month of the program more than 600 physicians were enrolled.

The challenge facing **MICHIGAN** policymakers was to increase participation in the state's EPSDT program without sacrificing its high standards of quality. The department of public health has long operated a system notable for its complex and rigorous EPSDT provider participation criteria. To participate in the program, a provider must be capable of performing all components of the EPSDT screen, except for dental exams. Strict protocols exist for each screening component that detail how various exams should be performed. The specifications even dictate the types of equipment EPSDT providers must use. On the one hand, these requirements ensure that EPSDT providers care for Michigan children in a very uniform and comprehensive manner. On the other hand, they also result in an almost completely closed system—only local public health departments typically can comply with the state's participation criteria. According to Medicaid officials, only 44 of the state's 10,000 licensed physicians currently participate in EPSDT. Such an approach certainly has contributed to the fact that only 48 percent of Medicaid children in the state are participating in EPSDT.

To resolve this classic "quality versus access" dilemma, the state has devised a creative, two-level system of participation. Beginning in July 1990, dual classifications were created allowing for both Comprehensive EPSDT Providers and Basic EPSDT Providers. Comprehensive providers that meet the state's rigorous participation criteria qualify for an enhanced, bundled fee for each child they serve. Basic providers provide any single component of the EPSDT package. Individual fee-for-service rates were established to reimburse providers for procedures such as well-child visits, immunizations, hearing tests, and developmental exams. Reimbursement structures were designed so that the single comprehensive fee is larger than the sum of all individual well-child fees, thereby maintaining an incentive for providers to strive to achieve "comprehensive" status.

State officials are addressing the concern that this approach may sacrifice some of the continuity and comprehensiveness assured under the old system. Certification processes are being revised to encourage more physicians to become Comprehensive EPSDT Providers.

and priorities, convening special training sessions with providers on topics such as billing and new program coverages, and recruiting new pediatricians into Medicaid using current pediatricians as recruiters. Eleven states have designated Medicaid or MCH staff as "provider liaisons" who are responsible for responding to provider concerns and for conducting ongoing recruitment.

Washington has aggressively confronted its provider participation problem with a number of strategies. The state recently received legislative authority to raise pediatric fees up to 80 percent of a statewide average of reasonable and customary charges for primary care procedures. To enhance claims submission and processing, billing codes were simplified. The state also initiated a new series of training sessions to teach pediatric providers how to more efficiently bill for Medicaid reimbursement.

Plans are being drawn to form a Pediatric Access Group that would consist of state MCH and Medicaid officials and representatives of private advocacy organizations. Plans call for the group to work with the state chapter of the American Academy of Pediatrics to persuade pediatricians of the benefits of the expanded Medicaid program.

The Medicaid and MCH agencies in North Carolina are jointly developing a number of county-based pilot programs aimed at recruiting greater numbers of pediatricians into Medicaid. The pilots will use currently participating pediatricians as recruiters, based on the belief that doctor-to-doctor communication is most persuasive. A key emphasis of the approach will be to discourage the competition over patients that often exists between local private and public providers. The state would like to foster the mutual understanding that there are too many children with no access to care for any one provider to be competing over those with access.

Georgia reports a very positive response from physicians to its new electronic billing and funds transfer system. Medicaid's fiscal agent supplies all participating providers with free computer software and staff training on how to use the software, so that all claims and payment can be handled electronically.

In response to OBRA-89, Missouri formed a special EPSDT Task Force to study children's needs, children's access to care, and how to improve the quality and effectiveness of health delivery systems. One charge of the task force was to devise a strategy to improve pediatric provider participation. Expanding upon work done with obstetricians in the state, Missouri surveyed pediatricians to learn more about their concerns and priorities. Using survey results, the task force has begun working more closely with pediatric societies to create a more effective program. For example, a new enhanced EPSDT fee was developed to create an incentive to provide comprehensive care—pediatricians that conduct a full screen will now receive $60 from Medicaid.

State efforts to reform and improve systems of care for children possess at least one distinct advantage over analogous initiatives for pregnant women: The willingness of pediatricians to care for low-income populations appears to be much greater than that of obstetricians. Historically positive ties between providers and public programs, coupled with a stronger public health orientation within the specialty, has meant that the supply of pediatricians participating in Medicaid and the EPSDT program has been plentiful.

However, new information from the American Academy of Pediatrics and from the NGA Survey of State Children's Health Initiatives indicates that this positive situation may be worsening. Greater numbers of pediatricians are reporting an unwillingness to participate in Medicaid, and officials in a growing number of states report that they are beginning to feel the pinch.

State efforts to retain or recruit pediatric providers in Medicaid programs are not widespread at this time. Yet a handful of MCH and Medicaid programs report new initiatives to prevent shortages from reaching crisis proportions, or to address documented access problems. These efforts are building upon the recent initiatives to recruit obstetrical providers into Medicaid, and are benefiting from the experiences of such proven strategies.

Part III: Restructuring Service Systems for Children

Devising a system for meeting the health care needs of children is a complex task. Such a system must be broad enough to provide every child with a standard, comprehensive, and appropriately timed set of preventive, well-child services. It must be responsive enough to treat any acute illnesses these children may suffer. It also must be targeted enough to provide special services to those children with chronic health and/or developmental problems. Unfortunately, the majority of public programs across the nation have only occasionally succeeded in creating systems that achieve any of these objectives. Still worse, state Medicaid and Maternal and Child Health programs have almost never been able to effectively address all priorities within a single system.

At the heart of this issue is the question of how effectively are states operating their Medicaid Early and Periodic Screening, Diagnostic, and Treatment programs. Since its inception in 1967 EPSDT has embodied the principle that all Medicaid children should receive regularly scheduled examinations to detect health, vision, hearing, and dental problems and, if needed, further diagnosis and treatment of any identified ailments. Integrally related is the question of how well state Title V Maternal and Child Health and Children with Special Health Care Needs (CSHN) programs are integrated with EPSDT. Answers to these questions critically hinge upon the traditional practice patterns of private, office-based pediatricians in a given community or state—do these providers tend to work within or outside the state's EPSDT/MCH/CSHN infrastructure?

The EPSDT program was revised dramatically by provisions contained in the Omnibus Budget Reconciliation Act of 1989. Generally, these changes strive to make the program more responsive to the individual needs of covered children and could potentially:

- *Reshape the way EPSDT screens are administered by disaggregating the comprehensive screen into component pieces and by expanding the numbers and types of providers eligible to perform partial screens; and*
- *Improve a state's ability to link screening services to treatment services because of a new requirement to provide any service needed to treat a condition identified by an EPSDT screen, even if that service is not covered by the state's Medicaid plan.*

One objective of the NGA Survey of State Children's Health Initiatives was to discover the degree to which states are reforming services and service delivery systems for children. While not the sole focus of survey questions, much of the information centers on EPSDT practices and responses to OBRA-89. The survey results offer insight on the various ways states currently administer EPSDT, the ways in which screens (and the rules surrounding who can screen) are being modified, whether states are being proactive or reactive in their approaches to providing treatment services, and how states can develop coordinated services and structures to integrate the multiple and diverse components of children's health care.

6. Administering EPSDT More Effectively

Since the program's inception, state approaches to administering the EPSDT program have evolved in numerous and diverse directions. The federal statute and the Health Care Financing Administration's *State Medicaid Manual* (Transmittal No. 3) provide states with great latitude in program design.

> You have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within your jurisdiction.

A basic requirement is that all eligible Medicaid recipients below the age of twenty-one must be informed of EPSDT and what the program can offer them. However, there are practically no limitations on how states structure this informing process.

> The intent of the statute is to allow flexibility...as long as the outcome is effective, and is achieved in a timely manner. The informing process, which may begin at the intake interview [can use a combination of] face-to-face, oral, and written informing activities.

It is this informing requirement that presumably has led so many states to couple the initial "outreach" to clients with the Medicaid eligibility process. From an efficiency standpoint, it can be argued that families should have program benefits explained to them at the same time their eligibility for the program is being determined. Alternatively, it can be argued that the long, complicated, and often confusing eligibility process is not the best time to focus families on the importance of preventive care. Because the chances are good that during this stressful period persons are simply too distracted to absorb this additional information, many states have designed informing systems that are separate from systems for eligibility determination.

The decision regarding where to place responsibility for EPSDT administration is an especially critical one for states. Administrative design decisions will influence how the program interacts with families on an ongoing basis. They also will determine the degree to which an EPSDT program can help families locate providers, make appointments, remember periodic screens, arrange transportation, and otherwise coordinate service delivery.

Eligibility-Based EPSDT Administration

The NGA Survey of State Children's Health Initiatives found that thirty-two states organize their programs around the Medicaid eligibility systems located in local

welfare departments (see Table 3). Under a typical scenario, the eligibility worker who is responsible for gathering applicant information and making the eligibility determination also is responsible for giving the family an orientation to EPSDT. The intent and benefits of the program are briefly explained, usually through the use of a brochure, and then the family is asked if they want to participate. Any family can decline EPSDT coverage.

Table 3
State Administration of EPSDT

Administrative Responsibility	*Number of States*
Eligibility Agency	32
With EPSDT Specialists (5)	
Without EPSDT Specialists (27)	
Maternal and Child Health or Other Agency	19
Local Health Departments (16)	
Community Agencies (2)	
Private Nonprofit Entity (1)	

SOURCE: National Governors' Association, Survey of State Children's Health Initiatives, 1990.

Active administration of EPSDT may or may not occur beyond this initial contact, depending on the state. In some states, interaction with the family essentially becomes a paper process. Staff might help mothers with making their initial appointment, an appointment reminder notice might be mailed to the family, and subsequent letters might be sent according to the state's periodicity schedule to alert the family about the need for additional checkups. In other states, family members are left on their own to locate a pediatric provider and then to follow his or her advice on the course of well-child care. Direct involvement with the family is very limited in these states.

A few states offer clients a more formal, focused orientation to EPSDT. In Arkansas, Connecticut, New York, North Carolina, and Ohio, most or all local welfare offices are staffed with specially designated EPSDT workers. On the same day families with children below age twenty-one are determined eligible for Medicaid, they are asked to meet with the EPSDT specialist to receive a more complete introduction to the program and a description of how it works. The EPSDT worker provides the family with a list of participating providers, assists with making the initial appointment, and helps arrange transportation if necessary. This specialist continues working with each family, reminding the family of the need for additional screenings. Ideally, the EPSDT specialists will regularly receive a report from Medicaid detailing the services each family has received to help them identify families that need additional follow-up. Although only five states currently administer EPSDT in this manner, the design was quite common in past years. Rising expenditures and fiscal constraints led many states to eliminate these staff positions during the 1980s (Children's Defense Fund, December 1990).

A very high proportion of states with eligibility-based EPSDT administration are dissatisfied with the approach. Nineteen of twenty-eight states agree that connecting EPSDT to the eligibility process undermines the potential effectiveness of the program. Medicaid and Maternal and Child Health officials either disagree or have no opinion on this issue in five states, while respondents in only four states believe that the system effectively manages the needs of families.

Confusion, anxiety, and information overload—inescapable by-products of an eligibility determination process—are the most commonly cited forces impeding effective orientation to the EPSDT program. Officials in three of the five states with full-time EPSDT specialists located in welfare offices even confirm that the close link to the eligibility system hampers their client outreach efforts.

Beginning in 1975, the **VERMONT** Health Department's MCH program assumed responsibility for EPSDT administration under a contract with the Medicaid agency. The contract calls for the department to provide outreach, education, and case management for all Medicaid-eligible families with children below age twenty-one.

The move reflected an attempt to improve what was viewed as an ineffective eligibility-based system. Under the former approach, the Medicaid application contained a question asking families with children if they wanted to participate in EPSDT. If they answered "yes," they were given a brief orientation by the eligibility specialist. If they answered "no," there was no further discussion of the benefit. Very low response rates persuaded Medicaid and health officials that the process was not properly informing families of the benefit, rather than indicating most families did not need help.

Under the present arrangement, families found eligible for Medicaid are informed by local social services staff that they will be contacted by someone from the local public health department. A list of these families is forwarded to public health agency staff who analyze and prioritize families to determine how they will be notified of EPSDT benefits. Families are then contacted and informed either by a home visit, phone, or mail. High-risk families are visited by a public health nurse.

During the home visit, a public health nurse determines whether or not the family has a regular pediatric provider, needs assistance with transportation, or is experiencing any particular health and/or psychosocial risks. Solutions to any problems are facilitated by the nurse. Families with particularly challenging needs receive ongoing care coordination.

Similarly, all families that receive the mailer are asked to contact the health department if they need help in locating a provider or getting to and from health care visits. Health department staff connect these families to participating physicians, transportation agencies, and any other agencies that may be of assistance. To ensure that all families understand that help is available, staff also telephone those who do not contact the office to discuss potential needs.

Depending on the qualifications and functions of local public health agency staff, the costs of their activities are supported by federal Medicaid matching dollars at either a 50 percent or 75 percent administrative rate. When administrative activities require professional medical knowledge and skills and are provided by qualified medical personnel, the state receives the higher match.

State officials in both the Medicaid and MCH agencies are pleased with the effectiveness of this approach. It provides a well-coordinated foundation for a program that strives to meet every child's unique needs.

EPSDT Administration Through MCH or Other Agencies

Using a very different approach to EPSDT administration, nineteen states contract with other entities to carry out general program management. Of these states, sixteen subcontract with public health agencies—typically the MCH program; two access local community agencies (including public health); and one state uses a private nonprofit firm to administer its EPSDT program (see Table 3).

Under a typical scenario, a local welfare office determines Medicaid eligibility for families with children below the age of twenty-one. Upon being determined eligible, families are told that another agency will contact them at a later date to explain the benefits available for their children. The local welfare office then generates a list of these families, with complete address and phone information, and forwards it to the subcontracting agency.

CALIFORNIA's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is administered jointly by the Child Health and Disability Prevention (CHDP) Branch of the Family Health Division and the Medical Care Services organization, both located within the Department of Health Services. The CHDP Branch is responsible for the provision of health assessments (screening), while the Medi-Cal (Medicaid) program provides follow-up diagnosis and treatment.

The screening portion of the program operates through local CHDP units located in health departments in fifty-eight counties and one city. Although there are variations among the local units, the basic systems operate in the following manner:

- The family's initial contact with the system is usually during application for AFDC and/or Medi-Cal. During the AFDC/Medi-Cal process, individuals are informed about the availability of EPSDT services and are asked if they wish to take advantage of them. If the response is affirmative, referral is made to a CHDP unit for follow-up. The follow-up contact may take the form of a letter, phone call, or personal visit. In some locations, a group information session is provided. Assistance with scheduling appointments with providers and with arranging transportation is provided, if needed. Local units generate periodic notices to parents reminding them of health assessment schedules.
- The CHDP case management function is made possible through information contained on the program's billing form. In addition to serving as a claim, this form contains a checklist of procedures completed and problems found during the screen. A copy of the claim form plus backup microfiche are regularly forwarded to the local CHDP units. CHDP units have the responsibility for following up on conditions identified during a screen, noting if referral for further diagnosis and treatment were made, and monitoring progress to ensure that the recommended treatment was received.

By using state funds, California has been able to establish a parallel program that provides health assessments for children not eligible for Medi-Cal from birth through age eighteen whose family income is equal to, or below, 200 percent of the federal poverty level. The state-funded program operates with the same procedures and benefits as the EPSDT program. State officials report a high level of satisfaction with the effectiveness of the CHDP program. Integral to the program's success is the strong support given to it by members of the private pediatric community (who perform 50 percent of all CHDP screens). These providers have become vocal proponents of the program. Many families receive their initial information about the program in the provider's office.

In the late 1970s Medicaid officials in **PENNSYLVANIA** decided that the state-managed EPSDT program needed to be changed. Persistently low participation rates, even lower rates of referrals for corrective treatment, and hiring freezes in local public assistance offices were contributing to less than ideal operations. Medicaid officials began to consider whether contracting for EPSDT administration with a qualified private nonprofit company might allow for a more effective, more flexible, and less expensive program.

Through the issuance of a request for proposals (RFP), Pennsylvania contracted the EPSDT program to two firms—one to provide services in Philadelphia County, the other to provide services in the remainder of the state. To consolidate the process, in 1987 the state issued another RFP and, after reviewing numerous competitive bids, awarded a contract to the firm of Automated Health Systems, Inc. (AHSI) to administer a statewide EPSDT program. Working out of two offices (in Pittsburgh and Philadelphia), the firm accepted the responsibility for all aspects of program administration, including ongoing marketing, client outreach and scheduling, provider outreach and relations, agency networking, case management, computerized claims processing, and report generation.

As the program currently operates, all Medicaid-eligible families receive an EPSDT brochure that explains the program's benefits, provides a toll-free hotline, and includes a detachable application form. All families that either mail in their application or call the hotline are entered into a centralized computer, sorted geographically, and assigned to one of twenty-five outreach staff. Outreach workers contact each family by telephone or letter to set up an appointment for a screen. On the same centralized computer system, outreach workers can access a file of more than 1,000 participating physicians, clinics, and hospitals. One week prior to their appointment, clients are mailed a reminder letter, and the day before their appointment they receive a reminder phone call. If conditions requiring further diagnosis or treatment are identified during a screen, the information is fed back to AHSI and the scheduling, reminding, and follow-up process begins again.

In addition to linking up with various health care providers, Pennsylvania's EPSDT contractor also has built formal relationships with other public, private, and community agencies. These entities are filed on the computer system and constitute other potential sources of valuable support for low-income families. For example, the EPSDT program has established a very effective reciprocal referral process with local Head Start programs that involves mutual notification of potential eligibles and recruitment assistance such as forwarding brochures and program information.

Early program experience suggests that this private company can perform certain functions better than the public agency. For example, AHSI has developed an attractive marketing campaign that, coupled with a simplified application (a detachable card on the program brochure), has worked well in drawing new clients into the program. Similarly, the firm has enjoyed relatively good success in recruiting new providers into EPSDT. Nine field staff travel throughout the state who have sole responsibility for contacting, recruiting, and training EPSDT providers. These staff focus recruitment efforts on both primary care and specialty providers so that the system can respond to both screening and treatment needs.

Data indicate that EPSDT is more effectively achieving its goals as a result of the change in program management. Prior to 1987 an average of 9,000 children per month received an EPSDT screen. Today that monthly average is more than 13,000. Operating a centralized system with a staff of forty-five, the private contractor has taken full control of a program that had been divided among sixty-seven counties and supported by about 100 local public assistance staff who performed informing duties in isolation from each other.

Other states are viewing the changes in Pennsylvania with interest. Louisiana, Montana, and New Mexico report that they are considering privatizing their EPSDT administration.

Through a face-to-face meeting in the agency or home, a phone call, or by mail, the agency provides families with an overview of the program. Each family's needs are discussed, potential providers are identified, and appointments are made. According to the state's periodicity schedule, the contracting agency will regularly contact the families to facilitate and manage their care on an ongoing basis.

The NGA Survey of State Children's Health Initiatives found that states using this approach to administer EPSDT generally believe their programs are more successful. From the perspective of both clients and program managers, Medicaid and MCH officials believe that EPSDT has a stronger identity as a *health care* program when administration is conducted by agencies other than welfare departments. Since in most of these states the person contacting the family is a public health provider, the fact that EPSDT is an important health care benefit is communicated more convincingly. Delinking EPSDT management from the eligibility determination process reduces clients' confusion and ensures that families will not be barraged by too much information in too short a period. Delinking also clarifies roles and responsibilities among public program staff; rather than forcing eligibility specialists to also manage a preventive health benefit, state officials can rely on health care providers to do the job they are best equipped to do.

7. Enhancing EPSDT Screening Services

The core of every state's EPSDT program is its screening service. Decisions regarding the design of this benefit determine not only the content and scope of the service that will be received by each Medicaid-eligible child, but also the type(s) of providers who will render the care.

According to Medicaid regulations, EPSDT screening services must include the following:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Appropriate immunizations according to age and health history;
- Laboratory tests (including lead blood level assessment appropriate to age and risk); and
- Health education (including anticipatory guidance).

At a minimum, EPSDT services also must include:

- Vision services, including diagnosis and treatment for defects in vision such as eyeglasses;
- Dental services, including relief of pain and infections, restoration of teeth, and maintenance of dental health; and
- Hearing services, including diagnosis and treatment for defects in hearing such as hearing aids.

Certain practices have become more or less institutionalized in state EPSDT programs throughout the years. For example, according to the NGA survey, about two-thirds of the states rely almost exclusively on private sector providers to deliver screening services. These providers are most commonly private, office-based pediatricians. One-third of the states use some combination of private and public providers; half of the EPSDT screens may be performed in public health clinics and/or Community Health Centers, while the other half may be performed in pediatricians' offices.

Survey results also indicate that only a small proportion of states make use of a detailed clinical protocol to guide the practices of EPSDT providers. About three-fourths of the states simply reference basic guidelines in their EPSDT provider

manuals and/or incorporate a checklist of items to be included in the screen on the billing form.

Several provisions in OBRA-89 promise to affect these common practices. Most important, the law mandates that states cannot limit the pool of EPSDT providers only to those who can furnish all the required EPSDT services, or prevent from participating those providers who can furnish only a part of the EPSDT service package. Further, states must develop distinct periodicity schedules for screening, vision, dental, and hearing services. Services can be provided at intervals other than those specified in the periodicity schedule when medically necessary to identify and treat a suspected illness or condition. The law also required the federal government to develop, by July 1990, EPSDT participation goals for each state, and states must annually report on the extent to which they are meeting these goals.

Together these provisions are likely to stimulate changes in the way states structure EPSDT screens, expand or revise the numbers and types of providers involved in EPSDT screening, and strive to achieve the overall objective of increasing the numbers of children who receive EPSDT screens. NGA survey findings offer some early insight on state responses to these statutory provisions.

Provider Participation in EPSDT

The driving force behind the OBRA-89 provisions was the concern that too few children were receiving EPSDT screens. Further, advocates and lawmakers alike believed that many children were not receiving the special types of screening services they needed.

By expanding the pool of providers available to children, the law aimed to mitigate both of these problems. It was anticipated that less demanding participation criteria would stimulate larger numbers of pediatricians to enroll in EPSDT. Moreover, it was hoped that unbundling the EPSDT screen components would encourage the participation of other specialty providers such as developmental psychologists. It was expected that the combined effect of the provisions would be to both improve overall access and enhance the quality of care by involving additional providers trained to perform assessments beyond the normal scope of pediatricians.

Unfortunately, the issues surrounding provider participation in EPSDT were blurry before the passage of OBRA-89 and remain so today. Some observers believe that states are intentionally excluding large groups of providers from EPSDT because of the way they are administering the program. By establishing criteria that require providers to render the entire package of EPSDT services to their patients, states are unfairly and/or arbitrarily reducing the numbers who can participate.

Others argue that such criteria are an important quality assurance mechanism. By enforcing the ideal of one-stop shopping—a strategy used successfully in perinatal initiatives— states are minimizing fragmentation and improving continuity of care for children. In addition, involving specialists to perform more detailed diagnostic services—the "D" portion of EPSDT—after a problem is detected by a screen, has always been both implied and permitted by program rules.

While all agree that state efforts to ensure comprehensive care are laudable, stringent participation criteria can also effectively reduce the number of providers participating in EPSDT. The net result is to decrease the number of children who can receive screens.

Interestingly, the NGA survey found that only ten states currently have special or extra participation criteria for their EPSDT providers (i.e., criteria that are different or more rigorous than those imposed upon other Medicaid-participating physicians/providers). In most of these states, these criteria simply consist of an additional provider contract which, when signed by the provider, commits him or her to render the full scope of care that a Medicaid-eligible child needs and/or arrange for all services that the provider cannot provide directly. In other words, the EPSDT provider agrees to act as the "medical home" for the child. Only in a few states are participation criteria much more onerous.

Perhaps what truly plagues state EPSDT programs is the fact that so many pediatricians (and other providers) serving Medicaid children choose not to render their care through the EPSDT structure. A "shadow" EPSDT program—a description coined by the Children's Defense Fund—is one in which physicians in a state render primary and preventive care to Medicaid-eligible children, though do so outside of the EPSDT program. A proclivity to retain independence and a perception of EPSDT regulations and reporting requirements as too restrictive influence many pediatricians to practice this way. The problem is not that children using these providers receive inadequate or low-quality care; rather the problem is that the state cannot monitor that care nor take active steps to ensure the quality of that care. By simply billing Medicaid for an office visit involving a child, the shadow program provider supplies no data to Medicaid indicating the types or intensity of care provided. Further, children who receive well-child care from shadow program providers do not get counted as having received an EPSDT screen (even though they may have received a comparable service), thereby contributing to artificially low EPSDT participation rates among children and an unfairly grim picture of how a Medicaid program may be performing. Finally, by not receiving a formal EPSDT screen, children serviced by shadow providers may not be made eligible for the extra treatment services to which they are entitled under EPSDT.

The NGA survey found that in only five states do Medicaid and MCH officials believe that shadow programs are not a problem. Thirty-five states believe that such practices are widespread. Twenty-four of these states believe that they cause significant problems in managing a primary and preventive care program.

Allowing Partial-Screening Providers. The OBRA-89 provision prohibiting states from excluding providers from participating in EPSDT because they cannot offer the entire scope of EPSDT screens and services implies that states must now permit the rendering of "partial" screens.* A partial screen can be defined as any

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* A literal reading of the law indicates that states may not limit providers of *diagnostic and treatment services* to only those providers who can render all such services. Therefore, the law's impact on screening services and screening providers is unclear.

preventive examination that focuses on one or a few of the components of the current EPSDT screening service.

Allowing providers to perform partial screens provides an opportunity to significantly increase the numbers and types of providers participating in the program. It also creates the potential for significant fragmentation of care, if EPSDT recipients receive portions of their care from several different providers and no single provider assumes the responsibility for coordinating such care.

Allowing partial screens could mean a significant departure from traditional policy in most states. NGA survey results indicate that prior to OBRA-89, only nine states permitted providers to explicitly bill for only portions of the EPSDT screen. However, at the time the survey was conducted very few states knew precisely how they would respond to OBRA-89 authority.

- Twelve states indicated that they will take no specific action, at least in the near term, in response to this provision. Without further guidance from HCFA and input from provider and advocacy groups, these states feel it is more prudent to await clarification.
- Officials in ten states said that they will allow providers to bill separately in each of the four primary screening components of EPSDT—comprehensive health/developmental, vision, dental, and hearing—but will not allow billing for any further subsets of these components. For example, these officials do not believe that the law requires them to permit a developmental psychologist to perform (and bill for) a developmental screen since this type of screen comprises only a portion of the comprehensive health exam.
- Only three states reported plans to redesign their screening benefit, incorporating new protocols and fee schedules for each discrete component of the screen. Wisconsin, for example, added four new procedure codes within its EPSDT billing structure: one for health education, one for outreach, and two for interperiodic follow-up visits.
- The remaining states were unclear about how they will respond.

Fueling this relative lack of action is the belief that disaggregating the EPSDT screen to allow multiple providers to render certain components will undermine one of the prime tenets of the program: comprehensive and continuous care. When asked if they are concerned that such action will contribute to a fragmentation of care for children, Medicaid and MCH officials in eighteen states answered affirmatively. Officials in four other states agree that it will contribute to fragmentation, but that this minus is worth the plus of increasing the number of providers performing screens of some sort. In ten states, Medicaid and MCH officials disagree on whether the provision will cause fragmentation problems, while officials in eight states either believe the provision will not cause fragmentation or are unsure of its impact.

Improving the Quality of EPSDT Screens. While not responding to a specific provision of OBRA-89, a large number of states are engaged in another activity that embraces the spirit of the law—improving the quality of EPSDT screens. In nineteen states efforts currently are underway to improve the scope and comprehensiveness of

the EPSDT screening protocols. In Florida, for example, nine questions were added to the state's screening instrument to detect mental health and developmental problems among children. Similarly, other states that are expanding their screening forms and protocols are including new questions on health education, nutritional risks, and health and psychosocial problems of older children.

More than half the states have not found it necessary to develop new, distinct periodicity schedules for vision, dental, and hearing services in response to OBRA-89. Twenty-seven states report that they already have such schedules in place, and three of these say that they are further liberalizing them to increase the frequency of scheduled visits. Fourteen states are in the process of implementing new schedules in response to the law. As a short-term strategy, many of these are simply applying their existing periodicity schedule for the comprehensive health exam to their vision, hearing, and dental services.

Discouraging Shadow EPSDT Programs. A substantial majority of states are making a concerted effort to address what they believe is the most serious provider issue in EPSDT: the existence of shadow programs. The NGA survey found that twenty-nine states are designing or implementing one or more strategies to increase the numbers of pediatricians formally participating in EPSDT and reduce the number of those providing well-child care to Medicaid children outside of the EPSDT system.

- Nine of these states either have or will increase the differential between EPSDT fees and reimbursement for routine pediatric office visits. In many states, the two fees are either exactly the same or so close that doctors have little incentive to take on the extra paperwork and reporting burden of EPSDT. By significantly increasing EPSDT fees or reducing office visit fees states hope to create a positive financial incentive to participate.
- Taking a more firm approach, eight states will no longer permit providers to bill for well-child care unless claims are submitted through the EPSDT system. Officials in these states see no reason to continue two parallel but different billing avenues.
- Eight states are planning special outreach/educational efforts for pediatricians designed to inform them of program changes and to recruit them into EPSDT. Many officials believe that a certain portion of nonparticipating pediatric providers do not fully understand the program and are not aware that higher fees are available under EPSDT.
- Four states have undertaken other activities designed to improve providers' outlook toward EPSDT. These usually involve the simplification of billing systems and/or procedure codes.

Children's Participation in EPSDT

With the OBRA-89 requirements for states to report annually to the Secretary of the Department of Health and Human Services on the number of children participating in EPSDT, and for the Secretary to develop annual participation goals, another

controversial issue was brought to the fore: the accuracy of existing EPSDT participation indicators.

States traditionally have submitted quarterly reports to the Health Care Financing Administration detailing certain basic participation information: the number of children eligible for EPSDT, the number enrolled in continuing care arrangements, the number receiving screening services, the total number of screens performed, and the number of eligibles referred for corrective treatment (HCFA Form 420, 1990). HCFA guidelines ask states to compile this information in various ways so that certain program indicators can be tracked. For example, by adding the number of children in continuing care to the number of children that have received screens and dividing this sum by the total number of eligibles, a participation ratio is calculated. Similarly, if the total number of screens performed is divided by the total number of eligibles, a screening ratio is derived.

Unfortunately, broad federal guidance and varying semantical interpretations have resulted in states reporting very different information under these basic categories. For example:

- Does the number of children eligible for EPSDT constitute all children below age twenty-one in a state's Medicaid program, or only those children in families that have agreed to participate in EPSDT?
- Precisely what is a "continuing care" arrangement? HCFA guidance states that a continuing care provider functions as a child's health care manager, performing the entire set of EPSDT services directly or referring the child to providers capable of rendering appropriate services. The NGA survey found that only sixteen states use this reporting category. Twelve states use it for all children enrolled in an HMO or similar prepaid plan, two use it for children who receive targeted case management services, one uses it for children in pediatric nursing homes, and one uses it for all children receiving care from a provider who has signed a special comprehensive care agreement. Given this variability, is it reasonable to assume that all children enrolled in continuing care are receiving EPSDT screens? Most state officials are not confident of this assumption.
- Since shadow programs are so prevalent, can well-child visits billed outside of EPSDT also be counted as screens since it may be assumed that the content of the exam is similar?

Not surprisingly, states have answered these questions inconsistently. Therefore, it is very difficult to compare EPSDT indicators across states. For example, Arizona and Colorado reported 1989 EPSDT participation rates of more than 90 percent. In the same year Delaware, Indiana, and Oklahoma reported participation rates of less than 10 percent. Clearly, states have experienced different levels of success in involving children in their EPSDT programs. Yet vast discrepancies like these probably reflect differences in reporting as much as they reflect any real differences in participation rates among states.

New EPSDT Reporting Rules. In July 1990 the Health Care Financing Administration issued two sets of guidance to state Medicaid programs. Transmittal No. 67 contains the revised reporting form—HCFA-416—that states began using October 1, 1990. HCFA-416 replaces HCFA-420 and reflects a number of differences and improvements. The new report will be submitted annually rather than quarterly, thereby reducing states' administrative burden. Further, the HCFA-416 breaks out specific reporting categories for the numbers of children receiving vision, hearing, and dental services. Finally, the new form incorporates more discrete age breaks, enabling states to report on children under age one, and children between the ages of one and five, six and fourteen, and fifteen and twenty. These changes will facilitate more meaningful reporting on the types of services being received and more useful analysis of participation rates among children of different ages (see Figure 2).

Transmittal No. 4 details each state's annual participation goal. The HCFA-established goals call for every state to achieve an 80 percent participation rate by the year 1995. Interim goals are included that reduce the difference between a state's current rate and the required 80 percent participation rate by one-fifth each year between fiscal 1991 and fiscal 1995. In fiscal 1989 the participation rate in the average state was 39 percent, leaving 41 percentage points to be achieved in five years (see Table 4).

Annual Participation Goals. Available data on the Medicaid program are far from perfect. The average EPSDT participation rate of 39 percent offers only a general idea of what actually may be occurring in any one state. However, any number is better than no number, and data collected through the HCFA-420 give analysts enough information to know that EPSDT is not reaching enough poor children. The numbers also provide convincing evidence that participation rates must improve.

The question still remains whether the actions taken by Congress and HCFA will move states closer to meeting the 80 percent EPSDT participation rate. If the numbers from which state participation goals are derived are so fundamentally and severely flawed, is the 80 percent threshold an artificial, or worse, meaningless goal?

When asked whether they think they can achieve an 80 percent participation rate by 1995, Medicaid officials in twenty-four states reported no. In only nine states are officials optimistic that the threshold is attainable. In all cases officials express frustration that federal officials are attaching more reality to the data than they deserve. They also believe that as long as EPSDT enrollment remains voluntary it is unrealistic to expect, and unfair to require, an 80 percent participation rate. Furthermore, because the OBRA-89 and OBRA-90 eligibility expansions may dramatically increase the number of children covered by Medicaid, states will face an even more difficult task in reaching the 80 percent participation target.

State Medicaid and MCH officials recognize that EPSDT programs have to do a better job of enrolling children and providing them with the types of screening services they need. Survey results also reveal an understanding that performance indicators are necessary to measure progress toward these goals. Yet without explicit definitions of the data elements and uniform rules that permit all states to consistently report comparable information, any effort to measure progress will be undermined. Before devoting much attention to the question of how well or how poorly states are achieving the new EPSDT participation goals, a serious overhaul of reporting guidelines is necessary.

Figure 2
Annual EPSDT Participation Report: HCFA Form 416

State _____ FY 19____	Cat.	Age Groups				
		Total	<1	1-5	6-14	15-20
1. Number of individuals eligible for EPSDT:	CN					
	MN					
	Total					
2. Number of eligibles enrolled in continuing care arrangements:	CN					
	MN					
	Total					
3. Number of eligibles receiving screening services:	CN					
	MN					
	Total					
4. Total number of eligibles provided child health screening supervision (Line 2 ÷ Line 3):	CN					
	MN					
	Total					
5. **PARTICIPANT RATIO** (Line 4 ÷ Line 1)	CN					
	MN					
	Total					
6. Total number of screening (examination) services:	CN					
	MN					
	Total					
7. **SCREENING RATIO** (Line 6 ÷ Line 1)	CN					
	MN					
	Total					
8. Number of eligibles referred for corrective treatment:	CN					
	MN					
	Total					
9. Number of eligibles receiving vision services:	CN					
	MN					
	Total					
10. Number of eligibles receiving preventive dental services:	CN					
	MN					
	Total					
11. Number of eligibles receiving hearing services:	CN					
	MN					
	Total					

NOTE: "CN" = Categorically Needy, "MN" = Medically Needy

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, May 1990.

Table 4
Children's Participation in EPSDT: Current Rate and Annual Participation Goals

State	1989 Proxy Rate*	Percentage Points Needed	Interim Goals by Fiscal Year 1991	1992	1993	1994	1995
Alabama	40%	40%	48%	56%	64%	72%	80%
Alaska	70	10	72	74	76	78	80
Arizona	96	--	96	96	96	96	96
Arkansas	28	52	38	49	59	70	80
California	63	17	66	70	73	77	80
Colorado	94	--	94	94	94	94	94
Connecticut	10	70	24	38	52	66	80
Delaware	7	73	22	36	51	65	80
District of Columbia	24	56	35	46	58	69	80
Florida	67	13	70	72	75	77	80
Georgia	44	36	51	58	66	73	80
Hawaii	28	52	38	49	59	70	80
Idaho	12	68	26	39	53	66	80
Illinois	57	23	62	66	71	75	80
Indiana	9	71	23	37	52	66	80
Iowa	9	71	23	37	52	66	80
Kansas	13	67	26	40	53	67	80
Kentucky	13	67	26	40	53	67	80
Louisiana	33	47	42	52	61	71	80
Maine	55	25	60	65	70	75	80
Maryland	49	31	55	61	68	74	80
Massachusetts	61	19	65	69	72	76	80
Michigan	48	32	54	61	67	74	80
Minnesota	34	46	43	52	62	71	80
Mississippi	33	47	42	52	61	71	80
Missouri	37	43	46	54	63	71	80
Montana	42	38	50	57	65	72	80
Nebraska	57	23	62	66	71	75	80
Nevada	62	18	66	68	73	76	80
New Hampshire	15	65	28	41	54	67	80
New Jersey	11	69	25	39	52	66	80
New Mexico	35	45	44	53	62	71	80
New York	15	65	28	41	54	67	80
North Carolina	54	26	59	64	70	75	80
North Dakota	19	61	31	43	56	68	80
Ohio	49	31	55	61	68	74	80
Oklahoma	7	73	22	36	51	65	80
Oregon	43	37	50	58	65	73	80
Pennsylvania	44	36	51	58	66	73	80
Rhode Island	45	35	52	59	66	73	80
South Carolina	79	1	79	79	80	80	80
South Dakota	21	59	33	45	56	68	80
Tennessee	27	53	38	48	59	69	80
Texas	24	56	35	46	58	69	80
Utah	32	48	42	51	61	70	80
Vermont	68	12	70	73	75	78	80
Virginia	52	28	58	63	69	74	80
Washington	35	45	44	53	62	71	80
West Virginia	56	24	61	66	70	75	80
Wisconsin	47	33	54	60	67	73	80
Wyoming	27	53	38	48	59	69	80
Average	39	41	47	56	64	72	80

NOTE: Fiscal 1989 ratio of continuing care enrollees and initial and/or periodic screening examinations to the average number of eligibles as reported on HCFA Form 420.

SOURCE: Adapted from July 1990 *State Medicaid Manual* (Transmittal No. 4), Health Care Financing Administration, U.S. Department of Health and Human Services.

8. Linking Treatment to Screens

Despite its name, which indicates that screening, diagnostic, and treatment services are to be provided, EPSDT has always succeeded far better as a screening program than as a treatment program. State administrators have focused on the importance of informing families of the benefit. Providers have focused on the delivery of comprehensive health examinations. Federal reporting rules have focused on the number of children screened and the number of screens performed. Virtually no attention has ever been paid to the question of how the treatment portion of the program should be carried out. Program rules and regulations have provided only limited, broad guidance regarding what treatment services should be covered, who can provide them, and how an appropriate benefit package might be designed.

Recognizing this traditional shortcoming, Congress took steps to resolve the problem through OBRA-89.

> States are required to provide any service that a State is allowed to cover with Federal matching funds under Medicaid that is required to treat a condition identified during a screen, whether or not the service is included in the State's Medicaid plan.

Prior to this statutory change, states were required only to provide any needed treatment service that was already covered under their state plan.

While OBRA-89 did not shed any light on how systems should be structured, it illuminated a critical issue: States need to do a better job of ensuring that children receive the treatment services they require after screening identifies their particular needs.

Levels of Exposure

With the passage of the treatment services provision, the initial task facing states was to determine the size of the service coverage gaps in their existing state plans. The NGA survey asked state officials to identify the types of services they believe their states will need to begin supporting more extensively.

Nineteen states indicated they will feel relatively few impacts in terms of increased utilization and/or expenditures as a result of the new law. Most often, these are states traditionally viewed as having generous programs such as Michigan, New York, and Vermont. Because coverage of optional Medicaid services is already extensive, these states do not foresee large numbers of new claims being submitted for services the state does not cover.

Another group of states expressed significant concern about costs and utilization, expecting both to increase substantially. Cost estimates in states with very large programs are striking: in Florida—$91.3 million and in Illinois—$30 million. Even certain states with relatively small programs anticipate a big impact: Louisiana—$17 million, Kentucky—$7-$10 million, Montana—$6-$7 million, and Nebraska—$6 million.

When asked to identify those services for which they anticipate a greater demand, officials from these states most often mention those related to meeting the needs of two populations: the mentally ill and the developmentally disabled. Fifteen states believe that they will be required to cover specialized mental health services, while eight states expect demands for inpatient psychiatric services. Therapeutic services for children with special needs were frequently cited, including occupational therapy (twelve states); physical therapy (nine states); and speech therapy (nine states). Other services identified by these states were private duty nursing, durable medical equipment, orthodontia, nutritional services, transplants, and case management.

Each year the Health Care Financing Administration publishes a chart specifying which states cover the various optional services that are identified in the Medicaid statute. Table 5 summarizes selected information from HCFA's October 1989 chart, highlighting states' coverage of optional services at the time OBRA-89 was enacted.

This information corroborates the concerns expressed by many state Medicaid officials. Many of the types of services needed by children with health problems, particularly developmental problems, are not covered by a large number of states.

Utilization Control

While OBRA-89 mandated that states cover all treatment services needed to treat or ameliorate a condition identified during an EPSDT screen, the law did not restrict states' authority to manage and oversee utilization. In fact, results of the NGA survey suggest that OBRA-89 may stimulate state Medicaid programs to place a renewed emphasis on effective prior authorization and medical necessity review procedures.

The law required many states to begin covering services that they previously had not covered. Similarly, it implies that states must do away with any existing limits on the amount, duration, or scope of coverage for children. As a result, states have begun to evaluate their administrative capacity to manage the utilization of treatment services.

At the time of the NGA survey nine states had eliminated specific day and/or dollar limits for certain treatment services, including inpatient psychiatric care, mental health services, and speech and physical therapy. As officials from these states interpret the statutory changes, there seems to be no further authority to maintain arbitrary limits if it can be demonstrated that a child requires continued care. Existing day limits are used as a means to trigger a case review for determining whether continued care is required, rather than as a rationale for discontinuing care.

Table 5
Selected Medicaid Optional Services Not Covered Prior to OBRA-89

State	*Physical Therapy*	*Occupational Therapy*	*Speech, Hearing, and Language Disorders*	*Private Duty Nursing*	*Inpatient Psychiatric Care*	*Personal Care*	*Respiratory Care*
Alabama		■	■	■		■	■
Alaska				■			■
Arizona					■		
Arkansas							■
California				■		■	■
Colorado	■	■	■			■	■
Connecticut		■				■	■
Delaware	■	■	■		■	■	■
District of Columbia							■
Florida	■	■		■	■	■	■
Georgia	■	■	■	■	■	■	■
Hawaii				■		■	■
Idaho		■	■	■	■	■	■
Illinois						■	■
Indiana						■	
Iowa				■			■
Kansas				■			■
Kentucky				■		■	■
Louisiana	■	■	■			■	■
Maine							■
Maryland		■		■			■
Massachusetts							■
Michigan				■			
Minnesota							■
Mississippi	■	■	■	■	■	■	■
Missouri	■	■	■	■			■
Montana							■
Nebraska		■					■
Nevada					■		
New Hampshire					■		■
New Jersey				■			■
New Mexico		■	■	■	■	■	■
New York							
North Carolina	■	■	■				■
North Dakota						■	■
Ohio						■	■
Oklahoma	■	■	■	■			■
Oregon							
Pennsylvania	■	■	■	■		■	■
Rhode Island	■	■	■	■		■	■
South Carolina	■	■	■			■	■
South Dakota		■		■	■		■
Tennessee	■	■	■	■		■	
Texas	■	■	■	■	■		■
Utah		■					■
Vermont				■		■	■
Virginia					■	■	■
Washington						■	
West Virginia		■					
Wisconsin							■
Wyoming		■	■	■	■	■	■
Total	14	24	17	24	13	25	42

SOURCE: Adapted from *Medicaid Services State by State*, Health Care Financing Administration, U.S. Department of Health and Human Services, October 1, 1989.

In the wake of OBRA-89, fourteen states either modified existing, or initiated more aggressive, prior authorization and medical necessity procedures for treatment services. Missouri and Oregon developed new prior authorization guidelines for services such as physical therapy. Nebraska Medicaid program officials asked their local chapter of the American Academy of Pediatrics to assist them in developing similar policies and procedures. Emulating a program already in place in Tennessee, Arkansas began contracting with a private prior authorization firm that specializes in managing utilization of inpatient psychiatric services.

Twenty-six states believe that their existing prior authorization systems can adequately respond to any effects of the OBRA-89 provisions.

Comprehensive Treatment Services for Children

Whether in response to OBRA-89 provisions or as a natural extension of recent perinatal reforms, states have begun to consider the steps needed to build a comprehensive health care system to meet the needs of children. A well-coordinated EPSDT program can provide the foundation for such a system by providing all children with routine, regularly scheduled well-child care. However, the scope of EPSDT must extend beyond preventive care to address children's acute illnesses and also coordinate the chronic, long-term needs of children with complex problems.

To develop this diverse capacity, states must establish effective, collaborative relationships between their Medicaid and MCH agencies. Experts within the state MCH division can advise Medicaid officials on the components of an effective preventive and primary care delivery system. Moreover, officials from MCH's Children With Special Health Needs program can shed light on what services are needed by children with chronic problems. These individuals also are typically involved with state coordinating councils—established under P.L. 99-457—and therefore can directly assist with integrating Medicaid and new programs for early intervention.

To build on the success of the Maternal Support Services Program (MSSP), **MICHIGAN** believed it was necessary to design an analogous package of preventive benefits for newborns. A joint proposal by MCH and Medicaid agencies was developed during 1990 for a new Infant Support Services Program. As proposed, the program would use an interdisciplinary team of nurses, social workers, nutritionists, and mental health specialists to meet the varied needs of high-risk newborns. Families with such babies would be eligible for nine visits during the first year of life, any or all of which can occur in the home. Nutritional and psychosocial counseling, parenting education, linkage to various treatment service providers, and early intervention would be some of the services that family members could receive. Only providers that can demonstrate access to each of the interdisciplinary specialties would be able to qualify as Infant Support Services providers.

Funding for the proposal was included in the Governor's fiscal 1991 budget, and legislation was introduced to implement the proposed program. However, due to the state's fiscal situation, the proposal was not funded. The concept still has broad support among legislators, and advocacy groups in the state are working to identify an appropriate financing mechanism.

An underpublicized fact is that under the EPSDT program states have always possessed the flexibility to waive normal comparability rules within Medicaid. They can craft specialized, innovative services for children that need not be extended to other Medicaid populations. The discretionary services portion of HCFA regulations state that:

> Any services under 42 CFR 440 not previously included as a required EPSDT service may be provided under EPSDT even if it is not available to all Medicaid-eligible individuals or it is provided in lesser amount, duration, and scope to others.

Some might argue that because of the treatment services provision of OBRA-89, the discretionary services option is no longer relevant. Current law requires all states to provide any service that a child may need to address his or her ailment. Yet the juxtaposition of these two provisions emphasizes the reality that states can now follow one of two possible courses of action:

- States can simply comply with the new mandate by reacting, on a case-by-case basis, to the individual treatment needs of covered children; or
- States can embrace the spirit of the discretionary services option and proactively design a comprehensive treatment services benefit for this group.

With the help of a transfer of general revenue funds from the state's Developmental Services, Health, and Children's Medical Services programs, **FLORIDA's** Medicaid officials added a broad list of new services to its EPSDT program to comply with the treatment services provisions of OBRA-89. Effective October 1990, Florida's enhanced package includes:

- Personal care services;
- Skilled nursing services, including increased payments for subacute care (i.e., ventilator-dependent children, etc.);
- Physical, speech, respiratory, and occupational therapy;
- Significantly expanded coverage of immunizations, durable medical equipment, and transplant procedures;
- Parenteral nutrition, antihemophilic blood factors, and other high-cost drugs;
- Expanded targeted case management for children with special health care needs and chronically mentally ill children;
- Pediatric extended care facilities coverage; and
- Private duty nursing;
- Specialized medical and nursing services for children in foster care.

Close collaboration between Medicaid and CSHN officials during the design phase resulted in a service package that was acceptable to both agencies.

Beginning in 1986, the **OKLAHOMA** Medicaid agency began covering a children's health clinic benefit through its EPSDT program. Using the discretionary services flexibility within EPSDT, the state designed a multidisciplinary approach to providing a wide range of preventive and treatment services. In addition to the traditional EPSDT screening and treatment services, the enhanced package includes psychosocial, nutritional, and child development services, and speech pathology and audiological services. The state's public health clinics are the providers qualified to render and bill for the enhanced services and, within these clinics, actual care is provided by registered dieticians, social workers, public health nurses, pediatric nurse practitioners, and physician consultants.

Funding for the enhanced benefit package was afforded through an agreement between Medicaid and the state's department of health. The department provides the state match to cover claims for the new services.

Although all children participating in the EPSDT program are eligible to receive any enriched services they may need, the link between the clinics offering the services and the private pediatricians participating in Medicaid is not as close as the state would like. Private pediatricians are encouraged to provide routine medical services and to refer any children needing further psychosocial support to the public health department clinics. However, this referral does not take place frequently. The problem is due, in part, to the historical lack of EPSDT participation by private physicians. The state is struggling to overcome its large shadow program by educating private providers more effectively about how the program works so that greater numbers will participate. It is hoped that once more physicians participate in the official EPSDT program, a stronger referral link between them and the public clinics will evolve.

In response to OBRA-89, **NEW MEXICO's** Medicaid program developed a broad set of benefits to address the special needs of the state's severely emotionally disturbed, developmentally delayed, and medically and developmentally at-risk children and adolescents. Between May 1990 and December 1991, the state phased in coverage of:

- Services rendered by master's-level practitioners in community mental health centers;
- Day treatment programs in free-standing psychiatric hospitals;
- Inpatient hospitalization in free-standing psychiatric hospitals;
- Case management for medically at-risk children and adolescents;
- Residential treatment center services;
- Services rendered by independent master's-level social workers;
- Psychosocial rehabilitation services delivered at sites such as residential treatment centers, group homes, noninstitutional day treatment programs, and home- and school-based treatment programs (intensity of services based on medical necessity);
- Personal care services;
- Respite care services;
- Private duty nursing; and
- Various therapeutic services, including speech, physical, and occupational therapy provided by licensed therapists.

To be eligible for the enhanced Medicaid benefits, all conditions must be identified during an EPSDT screen. In the case of inpatient psychiatric services, the practitioner to whom the child is referred is required to develop an individualized treatment plan with the child, the parents, and other health care professionals as appropriate. For all other services, the child's care manager develops the plan of care. Such plans are then submitted to Medicaid for prior approval. These expansions are expected to cost the state about $50 million by 1995.

The NGA survey found that very few states have taken advantage of the discretionary services authority to develop special benefit packages for children. Only a handful are offering marginal additions such as eyeglasses and hearing aids to their plan.

However, this situation appears to be improving. The NGA survey reveals that five states have recently taken steps to significantly improve the scope, continuity, and comprehensiveness of pediatric care under Medicaid. In Michigan and Oklahoma, special preventive services are being designed and/or provided to infants and their parents. Alternatively, Florida, New Mexico, and Utah are developing sophisticated treatment service packages for children with special needs.

While the number of states taking such progressive steps currently is quite small, responses to the NGA survey suggest that more state activity is likely. For example, MCH and Medicaid officials in thirty-four states report that their programs are working with the coordinating councils established under P.L. 99-457 on program planning and implementation of early intervention services. Of these states, sixteen indicate that their plans are being significantly influenced by input from the coordinating councils.

Cooperative budget planning also is occurring in a large number of states. Given the expectation that Medicaid will play an increased role in the financing of services for children with extensive health and/or developmental problems, many states voice support for maximizing federal funding of this care. In nineteen states Medicaid and MCH officials report that they already are jointly planning, or will support, the transfer of state health department funds from programs for Children with Special Health Care Needs into the Medicaid budget. Such interbudget transfers already have been made quite extensively by states expanding Medicaid eligibility and services for pregnant women. While they have proven problematic in some instances, with careful planning and appropriate involvement of MCH officials, cooperative program financing provides a powerful incentive to harness at least one federal dollar for every state dollar expended on behalf of a Medicaid-eligible child.

9. Building an Integrated Continuum of Care

Creating a health care program that can effectively and comprehensively meet the needs of children is a challenging task. The utilization of routine well-child services by all families must be monitored to ensure that each child receives regular, standardized checkups. Such data collection and analysis allow a program to track children as they grow, and will effectively identify any problems that a given child may develop.

The program also must have the capacity to respond to the needs of children when problems are identified. In-depth diagnosis may be needed, and treatment services subsequently arranged. Depending on the severity of problems a long-term plan of care may be needed to organize chronic care services.

Given recent provisions in OBRA-89, potentially large numbers of screening, diagnostic, and treatment providers might be serving one child. Ideally, the activities and records of each should be fed back to a single primary caregiver—whether a particular physician or public clinic—so that all of a child's health care needs are understood.

To accomplish these various and multiple objectives, it is imperative that states develop a flexible, integrated, well-coordinated service delivery system. Based on responses to the NGA survey, a key ingredient of such a system is a formal system of care coordination or case management.

Care Coordination: A Key Priority

An overwhelming majority of states indicate that they are very concerned about the lack of coordination of services for children. Officials in thirty-four states agree with the statement that especially given various provisions in OBRA-89, there is a need for some provider or agency to be made responsible and held accountable for assuring all screening and treatment services are coordinated and integrated. Officials in just five states believe that their existing delivery system is sufficiently coordinated. Medicaid and MCH officials disagree on this issue in four states. This recognition of the importance of care coordination is noteworthy, because it similarly underlies the emphasis states have placed on prenatal care coordination in recent years. Thirty-three states now operate perinatal care coordination services for Medicaid-eligible pregnant women (NGA 1990).

Although support for coordinated care is singularly strong, current statutory and regulatory authority permit diverse approaches to program coordination. Some coordination approaches emphasize administrative strategies for managing health

care delivery, while others focus on direct provision of care coordination services. Both approaches possess different strengths and weaknesses and both achieve different objectives.

Administrative Approaches to Coordination

States typically administer their EPSDT programs in one of two ways: daily program functions are carried out by the Medicaid eligibility agency, or these functions are contracted out to another agency such as the state public health department. When the Medicaid agency is the predominant player, it can be argued that no significant coordination of EPSDT services occurs. Families are informed of the benefit during the eligibility determination process, they are asked whether or not they are interested in receiving the service and, if so, they are left alone to locate and obtain well-child care from a list of participating Medicaid providers.

Alternatively, it can be argued that subcontracting offers an institutional framework to create a coordinated system. When states contract for EPSDT administration with Maternal and Child Health programs, community agencies, or private firms, many relationships that facilitate a more integrated process are established. Agency staff, whether public health nurses, social workers, or other ancillary providers, are entrusted with the responsibility to ensure direct contact with the family, facilitate linkage between the family and a screening provider, follow up with families that do not keep appointments for primary and acute care services, and regularly contact families when it is time for another well-child exam. States that use the subcontracting approach support these activities with state Medicaid dollars and receive federal administrative matching payments at one of two rates: 50 percent for activities carried out by nonprofessional staff, or 75 percent for activities that require the involvement of skilled medical personnel.

While officials in these states are reportedly satisfied with the ability of their administrative system to manage utilization of preventive and primary care, they also express concern about their system's capacity to serve children with more complex needs. For these clients, many state CSHN programs have traditionally administered care coordination systems with the support of Medicaid administrative matching funds (Association of Maternal and Child Health Programs 1989). However, officials in a growing number of states believe it is necessary to develop a more focused case management or care coordination service that is rendered by health care professionals.

Care Coordination as a Service

States have had the ability to offer targeted case management as an optional service under Medicaid since 1986. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provided this authority, defining the service as one that "will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services." To add the optional service, states must submit to the Health Care Financing Administration a plan amendment specifying the population who will be served, the service components that will be offered, the providers who will be permitted to render care, and the payment methods that will be used to

reimburse providers. The COBRA option gives states a unique opportunity to circumvent the usual comparability rules in the Medicaid statute in order to focus resources on high-priority populations.

Since the law's enactment thirty-five states have taken advantage of the authority. States providing targeted case management receive federal matching payments at the state's usual service rate, which ranges from 50 percent to 83 percent.

The NGA Survey of State Children's Health Initiatives found that eighteen of these thirty-five states currently use the authority to target children. These programs vary widely in focus and approach (see Table 6).

Table 6
Targeted Case Management Programs for Children

State	*Target Population*
Alabama	Handicapped Children Foster Children
Florida	Children with Special Health Care Needs Children With Mental Health Problems
Kansas	Ventilator-Dependent Children
Louisiana	Ventilator-Dependent Children
Maine	Developmentally Disabled Children Ages Zero to Five
Maryland	Children with HIV Below Age Two High-Risk Children Ages Zero to Five Infants and Toddlers Needing Early Intervention
Michigan	Medically Fragile Children
Mississippi	High-Risk Infants (and Pregnant Women)
Missouri	High Risk Infants (less than 1,500 grams) (and Pregnant Women)
Nebraska	Supplemental Security Income and AFDC-Related Children (with specific needs)
New Mexico	Developmentally Delayed and Disabled Children Severely Emotionally Disturbed Children
North Carolina	Children with Special Health Care Needs
South Carolina	Emotionally Disturbed Children
Tennessee	Children Ages Zero to Two
Utah	Children with Special Health Care Needs
Virginia	High-Risk Infants (and Pregnant Women)
Washington	All Children Needing Assistance in Obtaining Services
Wisconsin	Severely Emotionally Disturbed Children

SOURCE: National Governors' Association, Survey of State Children's Health Initiatives, 1990.

In the majority of states, case management services are targeted to chronically ill children with especially complex and costly care needs. However, four states have established care coordination services focusing on primary care that build on recently established systems for pregnant women. In Maryland, Mississippi, Missouri, and Virginia, care coordinators serving pregnant women also perform a risk assessment of the newborns and continue to manage the care of those infants exhibiting particular needs or risk factors.

While this level of state activity appears promising, the NGA survey provides reason for a cautious assessment. Discussions with most state officials reveal that targeted case management programs have little or no direct connection with the state's EPSDT program. Benefits most often were designed during the two years immediately following passage of COBRA by long-term care specialists who were attempting to manage the service utilization patterns of high-cost, chronically ill children. While it is possible that current recipients of targeted case management receive their care as a result of an EPSDT screen and referral, state officials indicate it is much more likely that recipients come from the existing caseloads of providers such as home health care agencies and long-term care institutions. Delivery systems for special needs children therefore are typically separate from, and not well integrated with, systems for providing primary, preventive, and acute care. In the states targeting high-risk newborns, similar gaps exist. Rather than evolving as a result of collaboration between EPSDT and CSHN experts, these programs have been developed largely from discussions among perinatal experts and have been crafted as a logical, short-term extension of prenatal care coordination initiatives.

However, there may be reason for optimism. Passage of the OBRA-89 EPSDT and MCH provisions, as well as P.L. 99-457, has stimulated states to think more broadly about financing services for children with special health care needs and about establishing more integrated service delivery systems. Of the eighteen states with operational targeted case management benefits, four were begun during 1990 and were developed as a result of significant interagency planning and development (Maine, New Mexico, North Carolina, and Utah). Further, the NGA survey found that another fourteen states are planning or considering adoption of targeted case management services for children with special health care needs (Alaska, California, Connecticut, Delaware, Georgia, Kansas, Missouri, Montana, Nebraska, New York, Ohio, Oregon, South Carolina, and Wisconsin).

Under a coordinated children's health system all children would receive the preventive screens they need and, upon identification of particular problems, receive all the treatment services they require. Management of such a system would need to occur at two levels:

- At one level, *all* Medicaid-eligible children's receipt of routine examinations and subsequent primary and acute care would need to be monitored.
- At a second level, *children with intensive needs* would need to be followed as they proceed through their continuum of care.

States have a strong interest in building well-integrated and coordinated delivery systems from both an effectiveness and efficiency perspective. During the last four years, a majority of states have formally endorsed this notion in their

Medicaid and Maternal and Child Health officials in **UTAH** were anxious to seize the opportunity presented by OBRA-89 to devise a completely integrated continuum of care for children. To accomplish this objective, they knew they would have to coordinate not only children's receipt of well-child screens, but also any subsequently needed acute or chronic treatment services. The state's solution was to design a two-level care coordination system.

Utah is one of nineteen states in which the MCH agency holds a subcontract from the Medicaid agency to manage the EPSDT program. With administrative funds provided by Medicaid, MCH hires about fifteen case managers to staff the state's local health departments. Traditionally, the local health departments receive from the Medicaid agency a monthly list of families who did not keep their appointments for their child's first EPSDT well-child visit. The case managers follow up with each family to determine why the appointment was not kept and what they can do to help the family keep the next scheduled visit.

This approach has proven effective, providing a basic well-child care coordination system to help ensure that all children in Medicaid receive the preventive screens they need. However, with the advent of the treatment services provisions of OBRA-89, the state also wanted to guarantee that children with needs beyond routine screenings also received their care as efficiently and effectively as possible. What was needed to complement the fundamentally coordinated preventive system was a more specialized, targeted management of children with complex acute and chronic care needs. Beginning in July 1990, Utah's Medicaid program began covering targeted case management services for children with special health care needs.

Relying on the expertise of the state's CSHN office, the new benefit is centered in local health departments and uses the skills of their nurses and social workers. Public or private providers who screen a child and detect a need for special care (e.g., mental health services, occupational, physical, or speech therapy, or early intervention), are required to refer that child to a local health department case manager. The case manager then verifies the medical necessity of each prescribed treatment, links the child to appropriate caregivers, and manages the delivery of all subsequent care with an eye toward ensuring both high quality and efficiency.

By formalizing this two-level system of care coordination, Utah has taken a positive step toward developing a truly comprehensive EPSDT program.

perinatal program reforms. Prenatal care coordinators are now reimbursable providers under Medicaid in thirty-three states (NGA 1990).

If care coordination is considered an integral component of a well-designed prenatal care delivery system, then it can easily be argued that such a service is even more necessary for a successful children's health delivery system. Systems for children do not share the advantage that prenatal systems possess of focusing on a relatively finite set of services delivered during a finite period. A health delivery system for children must encompass a staggering array of preventive, primary, and chronic care services and must be capable of responding to a given child's needs during the span of his or her entire life.

Part IV: Next Steps

10. Taking Advantage of Available Opportunities

Reasons abound for feeling both seriously concerned and cautiously optimistic about the state of states' health care systems for children. Without a doubt, state initiatives in this area are lagging considerably behind those involving prenatal care reforms. While states have made great strides in designing and implementing perinatal access and quality improvements, in many ways they are just getting started on children's health reforms.

A number of factors may facilitate more rapid progress. First, states can build upon their successes in prenatal care and incorporate many of the lessons learned from these initiatives into strategies for children. Collaborative relationships established between Medicaid and MCH agencies in recent years perhaps represent the most important development and may set the stage for further progress by involving Children with Special Health Care Needs programs. Second, states need not craft Medicaid-financed children's health care programs out of whole cloth, as often was the case with prenatal initiatives. Many strong EPSDT systems exist across the nation that can provide a firm foundation upon which to build.

State strategies to improve children's health care can benefit from a number of existing policy and program opportunities.

Opportunity # 1: Furthering Interagency Collaboration

During the last four years, state Medicaid and MCH officials have successfully worked together on perinatal system improvements. Combining expertise in both the financing and delivery of care, these collaborative efforts have fostered rapid advances. The opportunity currently exists to continue this dialogue and expand it to include experts in preventive and primary care for children, long-term care, home- and community-based services, and care for children with special health care needs so that effective continuums of care for children can be developed.

Opportunity #2: Streamlining Eligibility

Conversations with state officials repeatedly reinforce the notion that many of the strategies used to simplify eligibility processes for pregnant women can be refined to achieve the same results for children.

- Access can be greatly facilitated by outstationing eligibility workers at high-volume provider sites that serve women, children, and families. Workers stationed at hospitals could be specifically charged with contacting new mothers at the time of release in order to complete a Medicaid application on behalf of the newborn.

- States that have already simplified application forms to facilitate access for pregnant women can use this same strategy to improve access for young children. Few modifications need to be made to a pregnant women-only form to expand its use for children. For example, children can benefit from the same assets test exclusion as pregnant women, and only a few questions regarding absent parents might need to be added in order to identify possible third party sources of support. States that have not yet developed shortened forms should consider creating a form that can be used for both groups.
- Perinatal care coordinators, who often are charged with helping pregnant women complete the Medicaid eligibility process, can have their role expanded to also assist children.

Opportunity #3: Developing Children's Outreach and Marketing Plans

By building on successful and recognized prenatal care campaigns, states can develop public information and education strategies that promote preventive and primary care for children. Such an approach eliminates the need to reinvent the wheel and lessens any client confusion about an entirely new campaign with a new identity. The Health Care Financing Administration's willingness to provide administrative matching dollars to support prenatal outreach also should extend to well-child outreach.

Opportunity #4: Increasing Pediatric Provider Participation

Many states are well acquainted with the challenge of trying to ensure access to obstetrical care providers. Similarly, they might have to address the increasing pediatric shortage before it reaches crisis proportions. Two factors will work to the states' advantage in accomplishing this objective. First, pediatricians historically have been much more supportive of Medicaid and other public programs for low-income populations. Second, states already are actively devising multifaceted strategies to recruit and retain obstetrical providers (including fee increases, claims simplification, public relations/outreach improvements, and malpractice initiatives). These efforts can be broadened to incorporate the concerns of pediatric providers.

Opportunity #5: Developing Comprehensive Child Health Services

States should revisit their EPSDT program with an eye toward structuring a comprehensive preventive, primary, acute, and specialty care delivery system for children. This process involves numerous discrete but interrelated steps such as:

- Delinking EPSDT administration from the Medicaid eligibility process. According to numerous Medicaid and MCH officials, EPSDT appears to operate much more effectively as a health care program when management responsibilities are removed from eligibility agencies and are assigned instead to public health agencies. When health providers such as nurses conduct informing, education, health assessment, referral, and follow-up activities, an effective foundation for a preventive screening program can be established.

- Expanding the base of providers participating in EPSDT, while also striving to provide each child with a medical home. At present not enough children receive EPSDT screens. Worse yet, many other children do not receive the specialized screening services they need to assess complex problems. To compound these problems, most states report that a high proportion of physicians that provide well-child care do so outside of the EPSDT program. To achieve better screening rates states should increase the number of providers rendering EPSDT screening services. In taking such action, however, states must guard against fragmenting the care received by children. Rather than permitting multiple providers to each render care to one child, a single provider should be designated as the primary caregiver and given the responsibility for managing his or her entire continuum of care.

- Linking treatment services to screening services. Given the OBRA-89 provision that requires states to cover all necessary treatment services, states can proactively design and provide a comprehensive package of treatment services for children. Since the treatment needs of children often will encompass complex, costly chronic and long-term care, this exercise should stimulate the development of collaborative relationships among Medicaid officials, Children with Special Health Care Needs officials, and early intervention experts within the coordinating councils established under P.L. 99-457.

- Establishing an overarching coordination system. By coupling an administrative system that manages the delivery of preventive screens and primary and acute care services to all children with a formal case management service that arranges care for children with special needs, states can move toward an ideal objective: a fully integrated continuum of preventive, primary, and specialty care for children.

For more than four years, states have placed unprecedented emphasis on the goal of improving the health status of mothers and children. To date the lion's share of this effort has focused on infant mortality initiatives and prenatal care improvements. States are now beginning to refocus their energies on the preventive and primary care needs of children. Eligibility expansions under Medicaid have enabled the first critical step: financial access. Yet much more work needs to occur before this nation's children will enjoy widespread access to the high-quality care they deserve.

Appendix: Medicaid Fees for Early and Periodic Screening, Diagnostic, and Treatment Comprehensive Screen, State Fiscal 1989

Appendix: Medicaid Fees for Early Periodic Screening, Diagnostic, and Treatment Comprehensive Screen, State Fiscal 1989

State	*Fee*
Alabama	$35.00
Alaska	50.00
Arkansas	34.65
California	46.50
Colorado	39.69
Connecticut	22.65
Delaware	28.49
District of Columbia	50.00
Florida	35.00
Georgia	34.32
Hawaii	95.00
Idaho	39.00
Illinois	30.00
Indiana	50.00
Iowa	22.50
Kansas	37.00
Kentucky	N/A
Louisiana	62.19
Maine	30.11
Maryland	49.00
Massachusetts	47.00
Michigan	62.00
Minnesota	87.00
Mississippi	23.00
Missouri	28.00
Montana	19.22
Nebraska	35.00
Nevada	49.72
New Hampshire	25.00
New Jersey	23.00
New Mexico	38.53
New York	29.00
North Carolina	N/A
North Dakota	65.12
Ohio	31.06
Oklahoma	25.00
Oregon	24.38
Pennsylvania	33.50
Rhode Island	30.00
South Carolina	38.00
South Dakota	31.52
Tennessee	14.00
Texas	27.00
Utah	35.00
Vermont	25.00
Virginia	31.50
Washington	28.67
West Virginia	22.45
Wisconsin	31.00

NOTE: N/A means not available.

SOURCE: Unpublished data from the National Governors' Association and Physician Payment Review Commission.

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Caring for Kids: Strategies for Improving State Child Health Programs is one of a series of publications on state perinatal and child health program issues published by the Health Program unit within NGA's Center for Policy Research. Other recent publications addressing state perinatal program issues include:

Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs by Ian T. Hill. June 1988. $15.00. No. 18002.

Since early 1987, a majority of states have implemented expanded Medicaid programs for pregnant women and young children living in poverty. To improve these populations' access to early and appropriate prenatal care, numerous states are also streamlining their systems for eligibility and outreach. Extensive discussion of presumptive eligibility is included.

Estimating Medicaid Eligible Pregnant Women and Children Living Below 185 Percent of Poverty: Strategies for Improving State Perinatal Programs by Paul W. Newacheck. June 1988. $15.00. No. 18004.

This volume estimates potential Medicaid eligibles with incomes below 185 percent of poverty.

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